

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this time the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 104M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02707

Reg. Dist. No. ....

2770

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>ADAMS ARUNDEL</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY	
CITY (If outside corporate limits, write RURAL OR TOWN) <i>Cleber Burnie</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>		<i>3401-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Plaza Manor Conv. Home</i>				STREET ADDRESS (If rural give location) <i>2510 Madison Avenue</i>			
3. NAME OF DECEASED (Type or Print) (First) <i>Lula</i> (Middle) <i>Anderson</i> (Last)				4. DATE OF DEATH (Month) <i>Mar</i> (Day) <i>11</i> (Year) <i>1958</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>8-25-1907</i>	9. AGE last birthday <i>50</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>NO</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mildred Ferguson - 2510 Madison Avenue</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>443X</i>							
IMMEDIATE CAUSE (A) <i>Congestive heart failure</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive cardio-vasc. disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (IF EITHER, NOTIFY MEDICAL EXAMINER) DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Osteoarthritis general</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ..... 19....., to ..... 19....., that I last saw the deceased alive on ..... 19....., and that death occurred at <i>11:45 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Joseph Taler</i>				ADDRESS (Street, city, town, state) <i>102 Bd A Blvd. N.E. Cleber Burnie, Md.</i>		DATE SIGNED <i>Mar 12-58</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-18-58</i>		NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cemetery</i>		LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Charles R. Law</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i>		ADDRESS <i>802 Madison Avenue</i>	
DATE <i>MAR 18 '58</i>							

# CERTIFICATE OF DEATH

11

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
RECEIVED  
MAR 18 1958

BUREAU V. S.

MAR 18 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2771 CERTIFICATE OF DEATH

Reg. Dist. No. 02708

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>		c. LENGTH OF STAY IN 1b <b>16ys, 9mos, 2da</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital, Md.</b>		d. STREET ADDRESS <b>2714 E. Biddle</b>	
3. NAME OF DECEASED (Type or print) First <b>Leonard</b> Middle <b>Armstrong</b> Last		4. DATE OF DEATH Month <b>3</b> Day <b>21</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/17/1909</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months <b>21</b> Days <b>19</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Hole</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lee Morton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Glomerulo Nephritis</b> DUE TO (c) <b>Hypertensive Encephalopathy</b>			INTERVAL BETWEEN ONSET AND DEATH <b>since admission on 5/24/41</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic Reaction, Simple Type</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Hour a. m. <b>12</b> p. m. <b>12</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that I attended the deceased from <b>January 15, 1955</b> to <b>March 21, 1958</b> , that I last saw the deceased alive on <b>March 21, 1958</b> , and that death occurred at <b>5:05 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Hildegard Heard Reissmann</b> M.D.		ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>3/24/58</b>	
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/25/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. - MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Randolph Collick - 1412 E. PRESTON</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 31 '58</b>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 31 1938

RECEIVED

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #11 - Film G226 - 4/22/58 - mb

02709

2726

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN Is <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hospital</u>				f. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William FRANCIS Atwell</u>				4. DATE OF DEATH Month Day Year <u>3 20 1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/24/70</u>			
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Shadyside Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Thomas Atwell</u>				14. MOTHER'S MAIDEN NAME <u>EFFIE RAST</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Robert F. ATwell</u> Address <u>Shadyside Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial failure</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 19, 1958</u> to <u>March 20, 1958</u> , that I last saw the deceased alive on <u>March 19, 1958</u> , and that death occurred at <u>4:12 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Emily H. Wilson</u>				ADDRESS (Street, city or town, state) <u>Deale, Md.</u>		DATE SIGNED <u>3-21-58</u>			
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		22d. LOCATION (City, town, or county) (State) <u>Kalesville Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>				ADDRESS <u>Kalesville Md</u>		24a. REC'D BY REGISTRAR <u>26 158</u>			
				24b. REGISTRAR'S SIGNATURE <u>Deale</u>					

CERTIFICATE OF DEATH

BUREAU N. 3

MAR 26 1958

RECEIVED

2772

CERTIFICATE OF DEATH

02710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>SARATOGA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>				c. LENGTH OF STAY IN 1b <u>34 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>516 S. Campmeade Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Viola</u> First <u>Hannah</u> Middle <u>Bange</u> Last				4. DATE OF DEATH <u>March</u> Month <u>12</u> Day <u>1958</u> Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14 1885</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>—</u>				13. FATHER'S NAME <u>Harry Bowers</u>			
14. MOTHER'S MAIDEN NAME <u>Lara Gold Hammer</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>213 20 1449</u>				17. INFORMANT <u>Catherine Nicholson</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of descending Colon</u> 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular disease</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>10 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946</u> to <u>3/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/12/58</u> , 19 <u>—</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. L. Balle</u> M.D. <u>Linthicum</u>				ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>3/12/58</u>			
PHYSICIAN'S NAME (Type) <u>—</u>				22a. REC'D BY REGISTRAR <u>MART 1 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 15-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Lingley, Jr. Buair</u>				24a. ADDRESS <u>—</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1953

DATE OF DEATH

PLACE HERE

PLACE HERE

BUREAU V. S.

MAR 17 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SANNS NURSING HOME</u> <u>Anne Arundel Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville - Md.</u>				c. LENGTH OF STAY IN 1b <u>13 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANNS-Nursing-Home.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edge water - Md. Box-446</u>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>(Eliza)</u> Last <u>Beard</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb-19-1876</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>			
11. BIRTHPLACE (State or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Lemon Beall</u>				14. MOTHER'S MAIDEN NAME <u>Martha-Tucker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>  </u>			
17. INFORMANT <u>Mary V. SANN - Cecil Rd. Md.</u>				Address <u>Millersville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Acute Lobar Pneumonia.</u> DUE TO (b) <u>Hemiplegia right lateral</u> DUE TO (c) <u>Cerebral Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>				20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>			
21. I certify that I attended the deceased from <u>March 6-58</u> to <u>March 6-58</u> that I last saw the deceased alive on <u>March 6-58</u> and that death occurred at <u>11 A</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph L. Liskay</u> PHYSICIAN'S NAME (Type) <u>DR. JOSEPH LISKAY</u> <u>ODONTON, MARYLAND</u>				ADDRESS (Street, city or town, state) <u>Odenton Md</u> DATE SIGNED <u>3-6-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				22b. DATE THEREOF <u>3-8-58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Haps Chapel</u>				22d. LOCATION (City, town, or county) (State) <u>Edgewater, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 11 '58</u>			
ADDRESS <u>ANNAPOLIS, Md</u>				24b. REGISTRAR'S SIGNATURE <u>  </u>			

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 11 1936

RECEIVED

2774

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> ✓	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>CHILDRENS CENTER</u>		d. STREET ADDRESS <u>10 ANACOSTIA RD. SE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CWENDOLYN</u> - <u>BELL</u>		4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>15</u> <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5 1951</u>
9. AGE (In years last birthday) <u>6</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>REUBEN BELL</u>		14. MOTHER'S MAIDEN NAME <u>GEORGETTA RILEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>REUBEN BELL</u>		Address <u>10 ANACOSTIA RD. SE. WASH. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PNEUMONIA INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MENTAL RETARDATION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 11</u> , 19 <u>58</u> to <u>March 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MARCH 15</u> , 19 <u>58</u> , and that death occurred at <u>10:45 A.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>CHILDRENS CENTER LAUREL MD. 3-15-58</u>			
ACTUAL SIGNATURE <u>Margaret W. Mola</u>		M.D. <u>CHILDRENS CENTER LAUREL MD. 3-15-58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Margaret Mola</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belmont Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Belmont Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines + Co. 901-3rd ST. S.W.</u>		ADDRESS <u>WASHINGTON D.C.</u>	
24a. REC'D BY REGISTRAR <u>Mar 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 1

BUREAU V. S.

2727

CERTIFICATE OF DEATH

02713

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood - Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood</u>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Anne Arundel General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Reeves Bell</u>				4. DATE OF DEATH Month Day Year <u>3 - 11 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1889</u>	9. AGE (In years last birthday) <u>68</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Counsel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>S.P.R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>NASHVILLE, TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN BELL</u>				14. MOTHER'S MAIDEN NAME <u>MARIE GATLIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>W. 1</u>		17. INFORMANT Address <u>MABEL L. BELL HARWOOD MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic coronary artery disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>7/29/52</u> , 19 <u>52</u> , to <u>March 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 10</u> , 19 <u>58</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Harwood, Md.</u> DATE SIGNED <u>3-11-58</u>							
ACTUAL SIGNATURE <u>Emil H. Wilson</u>		M.D. <u>Lottman, Md.</u>					
PHYSICIAN'S NAME (Type) <u>Emil H. Wilson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-13-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jo Gaudin's Sons, Inc.</u>		ADDRESS <u>1176 P. Ave. NW.</u>		24a. REC'D BY REGISTRAR <u>MAR 13 1958</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2775

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>35 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home Care, Baltimore, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John J. Bohuslav</b>		4. DATE OF DEATH Month Day Year <b>June 4, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1923</b>
9. AGE (In years last birthday) <b>72</b> yrs		IF UNDER 1 YEAR: Months Days Hours Min. <b>72</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Skillworker, (ret.) Derby Steel Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Derby Steel Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>John J. Bohuslav</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT Address <b>Mrs. Theresa Bohuslav, Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peripheral Vascular Collapse</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterial Embolism Left Leg</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease Sys.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1st.</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/18/58</b> , 19__ to <b>3/2/58</b> , 19__, that I last saw the deceased alive on <b>3/2/58</b> , 19__ and that death occurred at <b>4:40</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>113 7th Ave Brookhaven, N.Y. 3/4/58</b>			
ACTUAL SIGNATURE <b>Leonard H. Flax</b> M.D.		113 7th Ave Brookhaven, N.Y.	
PHYSICIAN'S NAME (Type) <b>Leonard H. Flax</b>		<b>Baltimore, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>March 5/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Co.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Glen D. [unclear]</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 6 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>[unclear]</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2776

## CERTIFICATE OF DEATH

Reg. Dist. No.

02715

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>				c. LENGTH OF STAY IN 1b <b>2ys, 7mos, 3das</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital, Md.</b>				d. STREET ADDRESS <b>1521 McCulloh Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Avon</b> Last <b>Brooks</b>				4. DATE OF DEATH Month <b>3</b> Day <b>24</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>		9. AGE (In years last birthday) <b>59</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Brooks</b>				14. MOTHER'S MAIDEN NAME <b>Sarah</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-1297</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Aneurysm of Aorta</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Syphilitic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Instant death</b>  <b>Known to us since 8/21/55</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic Reaction, Paranoid Type</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21. I certify that I attended the deceased from <b>August</b> , 19 <b>55</b> , to <b>March 24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>March 24</b> , 19 <b>58</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Hildegard Heard Reissmann</b>				ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>		DATE SIGNED <b>3/24/58</b>	
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D.</b> <b>Crownsville State Hospital, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-29-58</b>		22b. DATE THEREOF <b>3-29-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jackson Funeral Home</b>				ADDRESS <b>976 E. Ave</b>		24a. REGISTRAR'S SIGNATURE <b>-----</b>	
				DATE <b>---</b>		24b. REGISTRAR'S SIGNATURE <b>-----</b>	

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02716

2777

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. LENGTH OF STAY IN 1b <u>9ys, 3mo, 8ds.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>				d. STREET ADDRESS <u>1155 E. Lombard Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Warren</u> Middle <u>Brooks</u> Last <u>Brooks</u>				4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/25/88</u>	9. AGE (In years last birthday) yrs. <u>69</u>	IF UNDER 1 YEAR: Months <u>3</u> Days <u>7</u> Hours <u>19</u> Min <u>58</u>	IF UNDER 24 HRS: Months <u>3</u> Days <u>7</u> Hours <u>19</u> Min <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Dennie Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Marshit</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or date of service] <u>No</u>			16. SOCIAL SECURITY NO -----		17. INFORMANT <u>Hospital Records</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition and Congestive Heart Failure</u> DUE TO <u>002X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Pulmonary Tuberculosis</u> DUE TO (c) <u>Arteriosclerosis with Psychotic Reaction</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----				
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> to <u>March 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 7</u> , 19 <u>58</u> , and that death occurred at <u>2:45</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>				ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/7/58</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>				<u>Crownsville State Hospital, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Sch. of Med.</u>		22d. LOCATION (City, town, or county) (State) <u>29 S. Greene St. Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese 1082 North St. Baltimore</u>				24a. REC'D BY REGISTRAR DATE <u>3/10/58</u> <u>MARY 2 58</u>		24b. REGISTRAR'S SIGNATURE <u>Conf. Mapp</u> (AP)	

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02717

2778

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>		c. LENGTH OF STAY IN 1b <b>2ys, 10mos, 2da</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital, Md.</b>		d. STREET ADDRESS <b>631 W. Lantvale</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>3</b> Day <b>23</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	
9. AGE (In years lost birthday) <b>90</b>		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>John H. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mary Alice Lightfoot</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Hospital Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>441X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>None</b> DUE TO (c) <b>None</b>				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with Arteriosclerosis</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>May 21, 1956</b> to <b>March 23, 1958</b> that I last saw the deceased alive on <b>March 23, 1958</b> and that death occurred at <b>9:10 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>3/24/58</b>				
ACTUAL SIGNATURE <b>Hildegard Heard Reissmann</b> M.D.				
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D.</b>		<b>Crownsville State Hospital, Md.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-28-58</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>WESTERN STAR</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>William A. Jackson</b>		ADDRESS <b>916 Pennsylvania</b>		
24a. REC'D BY REGISTRAR <b>MAR 27 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>		

BUREAU V. S.

MAR 1968

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2779

CERTIFICATE OF DEATH

Reg. Dist. No.

02718

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural - Dardsonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Portland Road, Dardsonville, Md</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Thomas</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Anne Arundel</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Sedona Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>J. Howard Beard</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 19____, and that death occurred at <u>4:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>J. Howard Beard</u> M.D.			
PHYSICIAN'S NAME (Type) <u>J. Howard Beard</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3.24-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Sabers</u>	22d. LOCATION (City, town, or county) (State) <u>Chesterfield, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William R. Smith</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>	
ADDRESS <u>108 1/2 W. 2nd St. Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

March 20, 1938

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BUREAU V. S.

MAR 20 1938

RECEIVED

March 20, 1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2728

## CERTIFICATE OF DEATH

02719

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>A. A. GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>201 CHEESAPEAKE AVE</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY CARRIE BROWN</b>				4. DATE OF DEATH Month Day Year <b>MARCH 1 1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/6/1903</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>GEORGE TROTT</b>			14. MOTHER'S MAIDEN NAME <b>HESTER BOYD</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>ROLAND A. BROWN</b>		17. INFORMANT <b>#2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CORONARY ARTERY DIS.</b> DUE TO (c) <b>UNKNOWN</b>							INTERVAL BETWEEN ONSET AND DEATH <b>14 HRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JANUARY 1955</b> , to <b>MARCH 1958</b> , that I last saw the deceased alive on <b>MARCH 1958</b> , and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward H. Beck</b>				ADDRESS (Street, city or town, state) <b>44 Southgate Ave ANNAPOLIS, MD</b>			
DATE SIGNED <b>3/3/58</b>				PHYSICIAN'S NAME (Type) <b>ANNAPOLIS, MD</b>			
22a. BURIAL, CREMAT ON, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/4/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF</b>		22d. LOCATION (City, town, or county) (State) <b>ANNAPOLIS MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor &amp; Sons</b>				ADDRESS <b>ANNAPOLIS, MD</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 6 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			

BUREAU V. S.

MAR 6 1958

RECEIVED

2729

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>DOA Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Long Point on the Severn</b>			
3. NAME OF DECEASED (Type or print) First <b>AVERY</b> Middle <b>T</b> Last <b>BRUNNER</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>6</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1897</b>	9. AGE (In years last birthday) <b>60</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printing Office</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>			11. BIRTHPLACE (State or foreign country) <b>Cleveland, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Emil Jacoby Brunner</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Bentz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>579-28-9251</b>		17. INFORMANT <b>Mrs. Vida Grace Brunner- Wife- same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4x0.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>30 Min</b> <b>5 Years</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Oct</b> , 19 <b>53</b> , to <b>Mar 6</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Mar 3</b> , 19 <b>58</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward G. Skeritt</b>				DATE SIGNED <b>3-8-58</b>			
PHYSICIAN'S NAME (Type) <b>Edward Skeritt MD</b>				ADDRESS (Street, city or town, state) <b>Gambrills, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 11, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>				ADDRESS <b>Annapolis, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 11 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 11

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02721

2730

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> COUNTY <u>C. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>Annnapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL HOSP.</u>		e. STREET ADDRESS <u>52 Shaw St.</u>	
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>E.</u> Middle <u>BRYAN</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-1903</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Helper Civil Engineer Inc.</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Annnapolis, Md.</u>	
12. BIRTHPLACE (State or foreign country) <u>U. S. C.</u>		13. CITIZEN OF WHAT COUNTRY?	
14. FATHER'S NAME <u>Thomas E. Bryan</u>		15. MOTHER'S MAIDEN NAME <u>Mary E. Butler</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		17. SOCIAL SECURITY NO. <u>218-05-0311</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		19. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Paul F. Guerin</u>		DATE SIGNED <u>3-15-58</u>	
EXAMINER'S NAME (Type) <u>PAUL F. GUERIN</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annnapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		24a. REGISTERED BY REGISTRAR <u>March 8 58</u>	
ADDRESS <u>Annnapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Edwards</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 10 1978

RECEIVED

## 2730 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Md.</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
CITY OR TOWN <u>Pasadena</u>		LENGTH OF STAY (In this place) <u>10 yrs</u>		STREET ADDRESS (If rural give location) <u>1101 1st St</u>		STREET ADDRESS (If rural give location) <u>1101 1st St</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1101 1st St</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1101 1st St</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Eugene</u> <u>Howard</u> <u>Bussey</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>3</u> <u>9</u> <u>1958</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b> <u>Nov 23, 1907</u>	<b>9. AGE last birthday</b> <u>50</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Accounting</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Illinois</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Robert H. Bussey</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Queenie Franklin</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-07-9242</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>John J. Bussey, Jr., 1101 1st St, Pasadena, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
1621 IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial infarction</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Coronary artery disease</u>							
STATING UNDERLYING CAUSE LAST.							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>None</u>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <u>11:00 AM</u>				<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> el work el work		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify</b> that I attended the deceased from <u>1958</u> , 19 <u>58</u> , to <u>1958</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/11/58</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>John J. Bussey, Jr.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>1101 1st St, Pasadena, Md.</u>		<b>DATE SIGNED</b> <u>3-13-58</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>March 13/58</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>London Park</u>		<b>LOCATION (City, town, or county)</b> <u>Baltimore, Md.</u> (State)	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>W. J. Bussey</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Elton Bernie, Jr.</u>		<b>ADDRESS</b>	
<b>DATE</b> <u>MAR 13 '58</u>							

INSTRUCTIONS

**1. TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

BUREAU V. S.

MAR 13 1958

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2731

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>300 Glenn Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>CARMAN</b> Last <b>CARMAN</b>				4. DATE OF DEATH Month <b>3/3/58</b> Day <b>19</b> Year <b>19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-23-1909</b>	9. AGE (in years last birthday) <b>48</b> yrs	IF UNDER 1 YEAR Months <b>48</b> Days <b>48</b> Hours <b>48</b> Min.	IF UNDER 24 HRS Months <b>48</b> Days <b>48</b> Hours <b>48</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>William W. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Mora Goodman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO <b>—</b>		17. INFORMANT <b>Edgar L. Carman</b>		Address <b>(2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive intra-abdominal hemorrhage due to</b> <b>Rupture of a tumor of the left Adrenal Gland</b> Conditions, if any, which gave rise to immediate cause (b) <b>—</b> (c) <b>—</b> DOE TO <b>—</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>—</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>1P</b> a. m. <b>—</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>3/4/58</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-6-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sr.</b>				ADDRESS <b>Annapolis Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 6 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Al Mesnick</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
EM 2.57

BUREAU V. S.

MAR 6

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2781

Items 7.3, 7.1, 1.113, 14.35 Film 3226 3-19-58 at 02221

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>				d. STREET ADDRESS <u>1351 W. North Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u></u> Last <u>Carter</u>				4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years last birthday) <u>74</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>??</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO <u></u>		17. INFORMANT <u></u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia; Septycemia</u>							
443X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u>							
DUE TO (c) <u>IO-12 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>December 9, 1957</u> to <u>March 8, 1958</u> , that I last saw the deceased alive on <u>March 8, 1958</u> and that death occurred at <u>9:28 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hildegard H. Reissman</u> M.D.				ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>			
DATE SIGNED <u>3/8/58</u>							
NAME (Type) <u>Hildegard H. Reissman</u>				Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u></u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy J. Wilson</u>				ADDRESS <u>2004 E. Enoch</u>		24. REC'D BY REGISTRAR <u>W. H. Beach</u>	
DATE <u>MAR 14 '58</u>							

RECEIVED

MAR 14 1958

BUREAU V. E.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2782

## CERTIFICATE OF DEATH

Reg. Dist. No. 02725

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>				c. LENGTH OF STAY IN 1b <b>1yr, 2mos, 14ds</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital, Md.</b>				d. STREET ADDRESS <b>None</b>			
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Powell</b> Last <b>Claggett</b>				4. DATE OF DEATH Month <b>3</b> Day <b>2</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Unknown</b>	
9. AGE (In years not birthday) yrs. <b>76?</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William Powell</b>				14. MOTHER'S MAIDEN NAME <b>Margaret</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) -----						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with Senile Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Hour a. m. ----- 19 p. m. -----				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from <b>November 19, 19 56</b> , to <b>March 2, 19 58</b> , that I last saw the deceased alive on <b>March 2, 19 58</b> , and that death occurred at <b>10:55aM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>		DATE SIGNED <b>3/3/58</b>	
PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>				Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>3/3/58</b>		<b>Sandy Spring, Md.</b>		<b>Sandy Spring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>				ADDRESS <b>Rockville, Md.</b>		24. REC'D BY REGISTRAR <b>7 MAR 7 '58</b>	
25. REGISTRAR'S SIGNATURE <b>[Signature]</b>				26. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 7 1969

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2783

## CERTIFICATE OF DEATH

Reg. Dist. No. 02726

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Mildred</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>MAR</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1906</u>
9. AGE (In years last birthday) <u>51</u> yrs		IF UNDER 1 YEAR IF UNDER 74 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (own home)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Blair Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Nellie M. Howard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Stanley C. Clark</u>		Address <u>8002 Piney Branch Road Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Vascular Disease</u> DUE TO (c) <u>Hypertension - severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u> <u>15 yrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Mar 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>18 Mar</u> , 19 <u>58</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2445 Marlboro Rd W. Wash</u> DATE SIGNED <u>12-18-58</u>			
ACTUAL SIGNATURE <u>R.B. Sassor</u> M.D.		PHYSICIAN'S NAME (Type) <u>R. B. Sassor</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 25, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner &amp; Humphrey,</u>		24a. RECEIVED BY REGISTRAR <u>26-58</u>	
ADDRESS <u>Silver Spring, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H.</u>	

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MAR 20 1970  
BUREAU X. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2784

CERTIFICATE OF DEATH

Reg. Dist. No. 02727

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel Co.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Pk.</b>				c. LENGTH OF STAY IN 1b <b>Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4905 Brookwood Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Cole</b> Last <b>Cole</b>				4. DATE OF DEATH Month <b>3</b> Day <b>27</b> Year <b>19 58</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1871</b>	9. AGE (In years last birthday) <b>86 yrs.</b>	10. IF UNDER 1 YEAR Months <b>86</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>Virginia</b>			
13. FATHER'S NAME <b>Dabney Baker</b>				14. MOTHER'S MAIDEN NAME <b>Lacy Atkinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Family</b>			
17. INFORMANT <b>Family</b>				Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cornary occlusion</b>							
4. DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) <b>Myocardial infarction</b>							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ischemic</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 19 56</b> to <b>Mar 27 19 58</b> , that I last saw the deceased alive on <b>Mar 27, 19 58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Philip H. Keister</b> M.D. <b>Seaton Ave W</b>				<b>3/28/58</b>			
PHYSICIAN'S NAME (Type) <b>KEISTER</b>				<b>DATE 25/1/58</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/31/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes 130 E. Fort Ave.</b>				24a. REC'D BY REGISTRAR <b>MAR 31 '58</b>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>			

10/58

RECEIVED

MAR 31 1953

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 02728

2732

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Lizzie Coleman</u>		4. DATE OF DEATH Month Day Year <u>3 11 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maids</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Franklin Hotel Annapolis, Md.</u>	
11. BIRTH PLACE (State or foreign country) <u>21. S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ferry Dobson</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>181-20-2742</u>	
17. INFORMANT <u>Man Jones</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction (Left Internal)</u> DUE TO <u>Cerebral Infarction (Left Internal)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>due to Hypertension</u> DUE TO <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>11 Days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 4, 1958</u> to <u>March 11, 1958</u> , that I last saw the deceased alive on <u>March 11, 1958</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u>		ADDRESS (Street, city or town, state) <u>M.D. 110 - CLAY ST ANNAPOLIS, Md.</u>	
DATE SIGNED <u>3/12/58</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-15-58</u>	<u>Brewer Hill</u>	<u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Seese</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>14 58</u>		24b. REGISTRAR'S SIGNATURE <u>Richardson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRITAIN V. S.

MAR 14 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2733

CERTIFICATE OF DEATH

02729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GENERAL</u>		d. STREET ADDRESS <u>10 CORNHILL ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERIC COLLINS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 18 1958</u>
9. AGE (In years last birthday) <u>1/2</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clifton Collins</u>		14. MOTHER'S MAIDEN NAME <u>ORA Blake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>ANNAPOIS</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>MALNUTRITION</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FEB. 18</u> , 19 <u>58</u> , to <u>MAR. 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MAR. 1</u> , 19 <u>58</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clayton Norton</u> M.D.		ADDRESS (Street, city or town, state) <u>95 CATHEDRAL ST. ANNAPOLIS</u>	
PHYSICIAN'S NAME (Type) <u>CLAYTON NORTON</u>		DATE SIGNED <u>W. H. Beach</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-5-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dailville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beech</u>		ADDRESS <u>108 N. 1st St. Annapolis</u>	
24a. REC'D BY REGISTRAR <u>W. H. Beach</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

WILLIAM V. S.

1958

DEALERS

2785

## CERTIFICATE OF DEATH

Reg. Dist. No.

02730

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D. C.</u> 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Children's Center</u>		d. STREET ADDRESS <u>911 O St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Connelly</u> Last <u>Connelly</u>		4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 2, 1913</u>
9. AGE (In years last birthday) <u>44</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Henry Connelly</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Garity</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Files of Children's Center, Laurel, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cirrhosis of liver</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>mongolism</u> <u>mental retardation</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>58</u> , to <u>Mar 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 26</u> , 19 <u>58</u> , and that death occurred at <u>5:45 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Children's Center, Laurel, Md.</u> DATE SIGNED <u>Mar 26, 1958</u>			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantravt, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantravt</u> <u>Children's Center Laurel Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-28-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DTS Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Jones, Jr.</u>		ADDRESS <u>Box DTS Laurel Md</u>	24a. REC'D BY REGISTRAR DATE <u>MAR 31 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>Willie Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR

RECEIVED

## 2785 CERTIFICATE OF DEATH

02731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN lb <b>2 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>CROWNVILLE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>COOK</b> Last <b>COOK</b>				4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 58</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/25/I 865</b>		9. AGE (In years last birthday) <b>92 yrs.</b>	IF UNDER 1 YEAR Months <b>92</b> Days <b>92</b> Hours <b>92</b> Min. <b>92</b>	IF UNDER 24 HRS Months <b>92</b> Days <b>92</b> Hours <b>92</b> Min. <b>92</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West River, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Frank Duvall</b>				14. MOTHER'S MAIDEN NAME <b>Mary Turner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Agnes Hawkins, 16, Pinkney St., Annapolis, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction assoc. with Cardiac Insufficiency</b> <b>420.1</b> DUE TO <b>Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> (b) <b>Arteriosclerotic Cardiovascular Disease</b> (c) <b>Arteriosclerotic Cardiovascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2-3 weeks</b> <b>15-20 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility, Bilateral Cataracts.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan. 20</b> , 19 <b>56</b> , to <b>March, 8</b> , 19 <b>58</b> that I last saw the deceased alive on <b>March, 8</b> , 19 <b>58</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital</b> DATE SIGNED <b>March 8, 1958</b>							
ACTUAL SIGNATURE <b>Ludwig Benedikt</b> M.D. <b>Crownsville State Hospital</b>				PHYSICIAN'S NAME (Type) <b>Ludwig Benedikt</b> <b>Crownsville, Md.</b>			
22a. BURIAL, CREMATON, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>3/12/1958</b>		<b>Brewer Hill, Annapolis, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Leese, Jr. - Anna, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 11 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the registrar after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the registrar after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2734

CERTIFICATE OF DEATH

Reg. Dist. No. 02732

1. PLACE OF DEATH a. COUNTY <u>Annapolis Md.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Annapolis</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>87 Washington St.</u>		d. STREET ADDRESS <u>87 Washington St.</u>	
3. NAME OF DECEASED (Type or print) <u>Rachel Ann Cook</u>		4. DATE OF DEATH <u>3-19-1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-1864</u>
9. AGE (In years last birthday) <u>94</u> yrs		10. IF UNDER 1 YEAR <u>94</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Self Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>491X</u>	
17. INFORMANT <u>Dr. R. Richardson</u>		Address <u>110-CLAY ST ANNAPOLIS, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Broncho-Pneumonia</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/16/58</u> , 19 <u>58</u> , to <u>3/19/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/19/58</u> , 19 <u>58</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, MD</u>	
ACTUAL SIGNATURE <u>R. Richardson</u>		DATE SIGNED <u>3/21/58</u>	
PHYSICIAN'S NAME (Type) <u>R. Richardson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-23-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Bessett</u>		ADDRESS <u>108 Wash St. Annapolis Md.</u>	
24a. REC'D BY REGISTRAR <u>Mar 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Richardson</u>	

RECEIVED

MAR 1970

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2787

Reg. Dist. No.

02733

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>24 Eugenia Avenue</u>				g. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Iola Marie Davis</u>				4. DATE OF DEATH <u>March 8th.</u>		19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/16/88</u>		9. AGE (In years last birthday) <u>69</u> yrs	10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired neck ties maker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Rudolph Norris</u>			14. MOTHER'S MAIDEN NAME <u>Hannah McMann</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-4974</u>		17. INFORMANT <u>Mr. R. Richard Davis (Son)</u>		Address <u>108 Glen Mount Ave Ferndale Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/8/58</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11 March 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bowdon Park</u>		22d. LOCATION (City, town, or county) <u>Balto Md</u>		(State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. McWaters</u>				ADDRESS <u>1414 E. Pratt St.</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>MAR 10 '58</u>				DATE <u>  </u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. COVER

1915

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2788 Item 7 CERTIFICATE OF DEATH

Reg. Dist. No.

02734

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>aa</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LENT BURG</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PLAZA MANOR</b>		e. STREET ADDRESS <b>1217 Mc Kinley St.</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN G. DAWSON</b>		4. DATE OF DEATH <b>Mar 23 1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-3-1872</b>
9. AGE (In years last birthday) <b>86 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster - Crabs</b>	
11. BIRTHPLACE (State or foreign country) <b>aa Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John W. Dawson</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>James E. Dawson</b>		Address <b>(2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerosis pericardial</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertrophy of prostate</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-15</b> , 19 <b>58</b> to <b>3-23</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3-23</b> , 19 <b>58</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph Taler</b> M.D.		ADDRESS (Street, city or town, state) <b>102 B &amp; A Bldg. N.E.</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH TALER, M.D. Glen Burnie, Md.</b>		DATE SIGNED <b>3-24-58</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-26-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Quaker Burial Grounds</b>		22d. LOCATION (City, town, or county) (State) <b>West River Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Saylor Sons</b>		ADDRESS <b>Annapolis Md</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	
DATE <b>MAR 26 '58</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2735

CERTIFICATE OF DEATH

02735

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis md</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Son's Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Feyton</u> Middle <u>A</u> Last <u>Deale</u>		4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881 Nov. 1</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>1</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ned Deale</u>		14. MOTHER'S MAIDEN NAME <u>Eareckson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>EMERSON DEALE</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute fibr. Hemorrh.</u> DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Hemiplegia bilateral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 months</u> <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u> (County) <u></u> (State) <u></u>
21. I certify that I attended the deceased from <u>March 7-58</u> to <u>March 17-58</u> , that I last saw the deceased alive on <u>March 17-58</u> , and that death occurred at <u>noon</u> on the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DR. JOSEPH LIPSEKEY</u> M.D.		DATE SIGNED <u>March 17-58</u>	
PHYSICIAN'S NAME (Type) <u>ODENTON, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>	22d. LOCATION (City, town, or county) (State) <u>GLEN BURNIE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lyle</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>19 58</u>	24b. REGISTRAR'S SIGNATURE <u></u>

BRUNAU V. S.

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## CERTIFICATE OF DEATH

2789

Item 12 Film G227 3-31-58 et

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR end give nearest town)  
TOWNLENGTH OF STAY  
(in this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWNHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSSTREET  
ADDRESS (If rural give location)3. NAME OF  
DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

4. DATE (Month) (Day) (Year)

OF  
DEATH

## 5. SEX

6. COLOR OR  
RACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

## 8. DATE OF BIRTH

## 9. AGE last birthday

## IF UNDER 1 YEAR

## IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)10b. KIND OF BUSINESS,  
OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT  
COUNTRY? U.S.A.

## 13. FATHER'S NAME

## 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. (B)II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH. (C)INTERVAL BETWEEN  
ONSET AND DEATH

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While ☐ Not while ☐  
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1957 to March 19, 1958, that I last saw the deceased  
alive on March 11, 1958, and that death occurred at 5:00 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

## 24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

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INSTRUCTIONS

**1** hours after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy of this certificate shall be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02737

2790

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Millersville (Rural)</u>		LENGTH OF STAY (in this place) <u>24 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Millersville (Rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crain Highway</u>				STREET ADDRESS (If rural give location) <u>Crain Highway</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Elver</u> (First) <u>Ann</u> (Middle) <u>Dicus</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>5</u> (Day) <u>17</u> (Year) <u>1958</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>12/31/1889</u>	<b>9. AGE last birthday</b> <u>68</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>AA County, md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>Charles Stinchcomb</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Wood</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>none</u>			<b>16. SOCIAL SECURITY NO.</b> <u>219-16-1097A</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs Dorothy Dicus, Same as 2</u>		
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>6 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>  </u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>  </u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH</b> <u>Carcinoma descending Colon</u>							
<b>19a. DATE OF OPERATION</b>			<b>19b. MAJOR FINDINGS OF OPERATION</b>				
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>			<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)			<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>		
<b>22. I hereby certify</b> that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-17</u> , 19 <u>58</u> , and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Charles R. MacDonell</u>				<b>ADDRESS</b> (Street, city, town, state) <u>1400 Burnie Maryland</u>		<b>DATE</b> <u>3-17-58</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>3/20/58</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Baldwin Memorial</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Severn Crossroads, AA Co</u>	
<b>24. REC'D BY REGISTRAR</b> <u>MAR 20 '58</u>		<b>REGISTRAR'S SIGNATURE</b> <u>W. Beach</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James S. Kirkley</u> <u>Hopping &amp; Kirkley</u> <u>Open Burnie, md</u>			

BUREAU V. 9

MAR 20 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02738

2791

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admss on) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>11 mos. 28 das</u>		d. STREET ADDRESS <u>218 N. Montford Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosie</u> Middle <u>Dix</u> Last <u>Dix</u>		4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>19 58</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/7/68</u>
9 AGE (In years lost birthday) <u>90 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Littleton Dix</u>		14. MOTHER'S MAIDEN NAME <u>Millie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with cerebral arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 3, 19 57</u> to <u>March 20, 19 58</u> that I last saw the deceased alive on <u>March 20, 19 58</u> and that death occurred at <u>11:30M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hildegard Heard Dix</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u>	
DATE SIGNED <u>3/21/58</u>		PHYSICIAN'S NAME (Type) <u>Hildegard H. Reissmann, M.D.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crownsville</u>		22d. LOCATION (City, town, or county) (State) <u>Crownsville State Hosp. Med.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Ward M.D. Dept</u>		ADDRESS <u>  </u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>MAR 26 '58</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 26 1960

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02739

2792

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>1yr, 7mo, 14ds</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Downes</u> Last <u>Downes</u>		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/1886?</u>
9. AGE (In years last birthday) <u>70?</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Irving Downes</u>		14. MOTHER'S MAIDEN NAME <u>Clara</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia secondary to decubital ulcers</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Known to us since 1956.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental Deterioration</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I attended the deceased from <u>June 22</u> , 1956, to <u>March 5</u> , 1958, that I lost saw the deceased alive on <u>March 5</u> , 1958, and that death occurred at <u>5:00a.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hildegard Reissmann</u> M.D.		ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>3/5/58</u>	
PHYSICIAN'S NAME (Type) <u>Hildegard Reissmann, M. D.</u>		<u>Crownsville State Hospital, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-7-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Deshuc</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>MAR 10 '58</u>	
ADDRESS <u>426 Dover St. Easton Md.</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

UNITED V. S.

MAR 10 1905

RECEIVED

2793 CERTIFICATE OF DEATH

Reg. Dist. No. 02740

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Anne's Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Anne's Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>163 Beacon Trail</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frances Agnes Eberhart</u>				4. DATE OF DEATH Month Day Year <u>March 15 1951</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIAGE STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16, 1883</u>		9. AGE (In years last birthday) yrs <u>74</u>	IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Newark, N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Phyllis A. Osborn</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Eberhart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT Address <u>Daughter, Mary E. Eberhart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral F. Liver (Fatty)</u> DUE TO <u>Diphtheria 11th L. L. S.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>none</u> DUE TO <u>none</u> (c) <u>none</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1-15</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>51</u> , to <u>3-16</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3-15</u> , 19 <u>51</u> , and that death occurred at <u>11:15</u> AM, from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Robert R. Halpern</u> M.D.				DATE SIGNED <u>3-16-51</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. Halpern</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer Cem.</u>		22d. LOCATION (City town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner</u> ADDRESS <u>17th</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Lickner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 18 1968

BUREAU W

02741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE					
Anne Arundel MARYLAND						Maryland Caroline					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Crownsville, Md.						Denton					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM?					
Crownsville State Hospital, Md.						R. F. D. #2 YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
Lena Emory						3 5 1958					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS	
Female		Negro				1/18/76		82		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY					
None											
11. BIRTHPLACE (State or foreign country)						12. CITIZEN OF WHAT COUNTRY?					
Maryland						U. S. A.					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Unknown						Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.					
No											
17. INFORMANT Address						Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, Hypostatic Pneumonia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cystopyelitis with hematoma DUE TO (c) Senility, Dehydration, Decubitus Ulcers											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Cerebral Arteriosclerosis											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.						20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from October 1957, to March 5, 1958, that I last saw the deceased alive on March 5, 1958, and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Lionel McHenry Mapp, M.D. Crownsville, Md. 3/7/58											
ACTUAL SIGNATURE						PHYSICIAN'S NAME (Type)					
Lionel McHenry Mapp						Lionel McHenry Mapp, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify)						22b. DATE THEREOF					
Removal						3/10/58					
22c. NAME OF CEMETERY OR CREMATORY						22d. LOCATION (City, town, or county) (State)					
U. of Md. Sch. of Med. (Anatomy)						29 S. G. Avenue St. Balto. Md.					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS						24a. REC'D BY REGISTRAR DATE					
William Reese 108 Wash. St. Annapolis, Md.						24b. REGISTRAR'S SIGNATURE					
						Carl W. M... ..					

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 12 1932

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02742

2795

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harundale, Glen Burnie</u> c. LENGTH OF STAY IN TB <u>?</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1518 Ingalls Rd. (About)</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harundale, F. C. Glen Burnie</u> d. STREET ADDRESS <u>1518 Ingalls Rd.</u> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Robert Lynn</u> Middle <u>Fielding</u> Last <u></u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>8th.</u> Year <u>1958</u>					
<b>5. SEX</b> <u>M.</u>		<b>6. COLOR OR RACE</b> <u>W.</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7/26/52</u>		<b>9. AGE</b> (In years last birthday) <u>5</u> yrs <b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u> Hours <u></u> Min <u></u> <b>IF UNDER 24 HRS.</b> Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u></u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>New York City, N.Y.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>Robert D. Fielding</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Laurel Stinckney</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mr. Robert D. Fielding (Father)</u> Address <u></u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull, Fracture of both femurs.</u> DUE TO <u>812X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury, or if fall, state direction.) <u>Ran from the front of his father's car and was hit by a car</u>					
<b>20c. TIME OF INJURY</b> Hour <u>12:20</u> p.m. Month, Day, Year <u>2/8/58</u> 19 <u>58</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>1518 Ingalls Rd.</u>		<b>20f. (City or town)</b> <u>Harundale, A.A.</u> (County) <u>Maryland.</u> (State) <u></u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>Gustave H. Faubert, M.D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>2/8/58</u>					
<b>EXAMINER'S NAME (Type)</b> <u>Gustave H. Faubert, M.D.</u>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>22b. DATE THEREOF</b> <u>3-10-58</u>					
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Riverside Cemetery</u>				<b>22d. LOCATION</b> (City, town, or county) <u>Rochelle Park, N.J.</u> (State) <u></u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hopping + Kirkley</u> ADDRESS <u>Glen Burnie</u>				<b>24a. REC'D BY REGISTRAR</b> <u>11 58</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u></u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 11 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02743  
Reg. Dist. No.

2736

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>md.</u> b. COUNTY <u>aa.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>General Hospital</u>		d. STREET ADDRESS <u>113 Main St</u>	
3. NAME OF DECEASED (Type or print) First <u>Antone</u> Middle <u>Fuehrer</u> Last <u>Fuehrer</u>		4. DATE OF DEATH Month <u>3-</u> Day <u>10-</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-3-1910</u>
9. AGE (In years last birthday) <u>47</u> yrs		10. IF UNDER 1 YEAR: Months <u>47</u> Days <u>47</u> Hours <u>47</u> Min. <u>47</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel Janitor</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Fuehrer</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> (If yes, give year or date of service) <u>WW II</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>BUREAU OF RECORDS U.S.N</u>		Address <u>WASHINGTON D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR DIS.</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/10</u> <u>1958</u> , to <u>3/10</u> <u>1958</u> , that I last saw the deceased alive on <u>3/10</u> <u>1958</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward J. Beck</u>		DATE SIGNED <u>4 Southgate Ave Annapolis 3/12/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-25-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Smith</u>	

BUREAU V. B.

MAR 26 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2796

## CERTIFICATE OF DEATH

Reg. Dist. No. 2744

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>Joyce Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>V.</u> Last <u>Gardner</u>				4. DATE OF DEATH Month <u>3</u> - Day <u>5</u> - Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 16-1884</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>3</u> Min.		IF UNDER 24 HRS Hours <u>3</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>aa Co Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Charles W. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Alice V. Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Ola Gardner</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis - Chronic</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>-</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 1951, to <u>March 4</u> , 1958, that I last saw the deceased alive on <u>March 4</u> , 1958, and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. G. de Ouedo, M.D.</u> M.D. <u>Arnold - Maryland</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>T. G. de Ouedo, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-7-58</u>		<u>Cedar Hill</u>		<u>Richie Highway aa Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

LIBRARY U. S.

MAR 10 1964

U. S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02745

2797

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>2mo, 25days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>2701 4</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Grandison</u> Last <u>Unknown</u>		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <u>Et</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>73?</u> yrs		IF UNDER 1 YEAR: Months <u>3</u> Days <u>4</u> Hours <u>1958</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>218-07-3701</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia, Decubitus Ulcers</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Dementia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m <u>19</u> p. m		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 7, 1957</u> to <u>March 4, 1958</u> that I last saw the deceased alive on <u>March 4, 1958</u> and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>3/6/58</u>			
ACTUAL SIGNATURE <u>Hildegard Heard Reissmann</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissmann, M. D.</u> <u>Crownsville State Hospital, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-8-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>W. Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balti Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clifton Wainwright Edmondson</u>		24a. REC'D BY REGISTRAR DATE <u>3-7-58</u>	
ADDRESS <u>2701</u>		24b. REGISTRAR'S SIGNATURE <u>Red Smith</u>	

BUREAU V. S.

MAR 7 1900

1870

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 311 8227 4-2-58 e+

2798

## CERTIFICATE OF DEATH

Reg. Dist. No.

02746

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ferndale</b>				c. LENGTH OF STAY IN 1b <b>7 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>307 Ferndale Avenue</b>				e. STREET ADDRESS <b>307 Ferndale Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>A.</b> Last <b>Grouling</b>				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 29, 1885</b>	9. AGE (In years for birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Warehouse Foreman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>George Grouling</b>				14. MOTHER'S MAIDEN NAME <b>Margaret ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-03-1496</b>		17. INFORMANT Address <b>Mrs Ella Grouling 307 Ferndale Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A.S.C.V.H.-R.D.</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Oct 57 - 27 March 58</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Oct</b> , 1957, to <b>March</b> , 1958, that I last saw the deceased alive on <b>17 March</b> , 1958, and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. R. Sosnowski</b>				ADDRESS (Street, city or town, state) <b>4016 Ritchie Hwy</b>			
PHYSICIAN'S NAME (Type) <b>A. R. Sosnowski</b>				DATE SIGNED <b>Balto 25-Mch.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 28, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn, Anne Arundel County</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc.</b>				ADDRESS <b>403 S. Wolfe Street</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 26 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>			

RECEIVED

MAR 26 1960

RECEIVED

2799

## CERTIFICATE OF DEATH

02747

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A. A. Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institutions: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>A. A. Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn (Arundel Village)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn (Arundel Village)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5336 - 4th St.</b>				d. STREET ADDRESS <b>5336 - 4th St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARVEY FLETCHER GUY</b>				4. DATE OF DEATH Month Day Year <b>March 20, 19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1889</b>		9. AGE (In years last birthday) <b>68 yrs</b>	IF UNDER 1 YEAR Months Days Hours M.in.	IF UNDER 24 HRS M.in.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Communications</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis F. Guy</b>				14. MOTHER'S MAIDEN NAME <b>Mary S. Powell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Helen I. Guy - 5336 - 4th St., Brooklyn</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gracchwiditis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>4 years</b>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 25, 1953</b> , to <b>3/14, 1958</b> , that I last saw the deceased alive on <b>2/14, 1958</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Sidney R. Gehlert</b> M.D. <b>4700 Pennington Ave.</b>							
PHYSICIAN'S NAME (Type) <b>Sidney R. Gehlert, M.D.</b> <b>4700 Pennington Ave. Balto. 26, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/24/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Shirley Lickner Y. Lewis - Baltimore</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO MEDICAL EXAMINER: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BERNARD V. ST

MAR 24 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ARUNDEL ON THE BAY RD</b>		/d. STREET ADDRESS <b>ARUNDEL ON THE BAY RD RT 3</b>	
3. NAME OF DECEASED (Type or print) First <b>KENNETH</b> Middle <b>L</b> Last <b>HAAS</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>31</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 24, 1941</b>
9. AGE (In years last birthday) <b>16</b> yrs.		IF UNDER 1 YEAR Months <b>16</b> Days <b>31</b> Hours <b>19</b> Min. <b>58</b>	IF UNDER 24 HRS. Months <b>16</b> Days <b>31</b> Hours <b>19</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sr. High School</b>	
11. BIRTHPLACE (State or foreign country) <b>Belmont, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles B. Haas</b>		14. MOTHER'S MAIDEN NAME <b>Alice C. Masters</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-38-8677</b>	
17. INFORMANT <b>Charles B. Haas- Father- same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Suicide</b> <b>716 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>under</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Suicide - 30-30 Winchester used</b>	
20c. TIME OF INJURY Hour <b>9:30</b> P. M. Month, Day, Year <b>March 31 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>nr Annapolis Anne Arundel Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Elmer G. Linhardt</b>		DATE SIGNED <b>March 31, 1958</b>	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>		22b. DATE THEREOF <b>April 2, 58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chestnut Level Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Belmont, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Maryland</b>	
24a. REC'D BY REGISTRAR <b>APR 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alvin</b>	

APR 7 53

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03066

2800

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 5ys, 7mos, 22das	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS R. F. D.	
3. NAME OF DECEASED (Type or print) First Middle Last Annie Mae Hall		4. DATE OF DEATH Month 3 Day 28 Year 19 58	
5 SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 80? yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Tom Johnson		14. MOTHER'S MAIDEN NAME Eliza Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 355x Chronic Brain Syndrome associated with Senile DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Brain Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Senile Brain Disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955, to March 28, 1958, that I last saw the deceased alive on March 28, 1958, and that death occurred at 7:25 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. Crownsville, Md. 3/30/58 PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/2/58	22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital	22d. LOCATION (City, town, or county) (State) Crownsville Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR APR 7 1958	24b. REGISTRAR'S SIGNATURE

UREAU V. S.

APR 7

RECEIVED

FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> <u>Same</u> COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Millersville</u>		c. LENGTH OF STAY IN 1b <u>5 Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Elm Rd. Elvaton</u>		e. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) <u>William James Hardy</u>		4. DATE OF DEATH Month <u>March</u> Day <u>28th.</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/18/00</u>
9. AGE (In years last birthday) <u>57 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Joseph Hardy</u>	
14. MOTHER'S MAIDEN NAME <u>Julia Ryan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Catherine Maffa, 741 Overbrook Rd. Balt.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Charred above recognition</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Due to</u> (c) <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>7.55 a.m. 3/28/58 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Elvaton, P.O. Millersville, A.A. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Raubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Raubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24. REC'D BY REGISTRAR	
ADDRESS		DATE	
25. REGISTRAR'S SIGNATURE		DATE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

RECEIVED  
JAN 10 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02749

2893

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived) IF institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>		c. LENGTH OF STAY IN 1b <b>2ys, 1mo, 11da</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Hayden</b> Last <b>Hayden</b>		4. DATE OF DEATH Month <b>3</b> Day <b>18</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/20/18-93</b>
9. AGE (In years last birthday) <b>64</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>6</b> Days <b>18</b> Hours <b>18</b> Min <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Clem Hayden</b>		14. MOTHER'S MAIDEN NAME <b>Sarah</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W. W. I</b>		16. SOCIAL SECURITY NO <b>217-09-7588</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocardial Infarction</b> DUE TO (c) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome due to Arteriosclerotic Hypertensive C. V. D.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>10</b> p. m. <b>15</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 7, 1956</b> to <b>March 18, 1958</b> , that I last saw the deceased alive on <b>March 18, 1958</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Hildegard Heard Reissmann</b> M.D. <b>Crownsville, Md.</b>		DATE SIGNED <b>3/18/58</b>	
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/22/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>	22d. LOCATION (City, town, or county) (State) <b>Hollywood Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. C. Clarke Mattingley</b>		24a. REC'D BY REGISTRAR <b>W. C. Clarke</b>	
ADDRESS <b>Leonardtown Md</b>		24b. REGISTRAR'S SIGNATURE <b>W. C. Clarke</b>	

RECEIVED

1953

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02750

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b> c. LENGTH OF STAY IN 1b <b>3 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 393 Deep Creek</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b> d. STREET ADDRESS <b>Box 393 Deep Creek</b>	
3. NAME OF DECEASED (Type or print) <b>CLARENCE A. HEATER</b>		4. DATE OF DEATH Month <b>March</b> , Day <b>17</b> , Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>	
11. BIRTHPLACE (State or foreign country) <b>Terre Haute Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW - 1</b>		16. SOCIAL SECURITY NO <b>218-09-0653A</b>	
17. INFORMANT <b>Carl E. Frantz Sr.</b> Address <b>1518 McHenry St 23 Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Lobar Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Cirrhosis of the Liver</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <b>Autopsy</b> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		DATE SIGNED <b>3/18/58</b>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>26/Mar/ 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Fredrick Road Balto. Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles W. Bachman</b>		24a. REC'D BY REGISTRAR <b>MAR 27 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Seach</b>

BUREAU V. S.

MAR 27 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02751

Reg. Dist. No

2805

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Baltimore 26</u> c. LENGTH OF STAY IN TB <u>2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hawkins Point</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>621 E. 35th Street</u> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Henry Heinecke</u> First Middle Last 4. DATE OF DEATH <u>March 10th. 1958</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>9/13/04</u> 9. AGE (In years months & days) <u>53</u> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscaper</u> 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Heinecke</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>220-09-2963</u> 17. INFORMANT <u>Mrs. Alice Heinecke (wife)</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Skull</u> <u>910.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>910.8</u> (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>was pushed by a tree against the track of a crane.</u> 20c. TIME OF INJURY Month, Day, Year <u>9:30 AM, 3/10/58</u> 19 Hour a.m. p.m. 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Improving ground, Baltimore 26</u> 20f. (City or town) (County) (State) <u>A.A. Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Mar. 13/58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u> 22d. LOCATION (City, town, or county) (State) <u>Md.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/10/58</u> DATE SIGNED	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Hennington</u> ADDRESS <u>2024 Orleans St. 31</u> 24a. REC'D BY REGISTRAR <u>3/10/58</u> 24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 10 days. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 10 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02752	
Item 7, Film G227, 4/7/58											
Items 8 & 9, Film G227, 4/15/58											
CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					b. NAME Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital					d. STREET ADDRESS 216 Arundel Beach					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First EDNA		Middle F		Last HENDERSHOT		4. DATE OF DEATH Month March Day 25 Year 19 58		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 1883 April 27, 1884		9. AGE (In years last b rthday) 73 3/4 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY CEN Plant		11. BIRTHPLACE (State or foreign country) NEBRASKA, U.S.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William S. Cook						14. MOTHER'S MAIDEN NAME Lillian					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. None		17. INFORMANT Name John Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic insufficiency										1 week	
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										3 months	
DUE TO											
(b) Chronic obstruction of bile duct											
(c) Carcinoma of Ampulla of Vater										?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3-5-58, 19, to 3-25-58, 19, that I last saw the deceased alive on 3-24-58, 19, and that death occurred at 1:30 AM, from the causes and on the date stated above.											
ADDRESS (Street, city or town, state)										DATE SIGNED	
ACTUAL SIGNATURE Jesse L. Wilkins										M.D.	
PHYSICIAN'S NAME (Type) JESSE L. WILKINS, M.D.										98 Cathedral St., Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)		
Burial				March 25, 1958		Cen Plant			Severna Park, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Jesse L. Wilkins						ADDRESS			24a. REC'D BY REGISTRAR DATE MAR 28 1958		
									24b. REGISTRAR'S SIGNATURE		

BURMAN K. M.

MAR 22 1958

LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2806

## CERTIFICATE OF DEATH

Reg. Dist. No.

02753

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>		c. LENGTH OF STAY IN 1b <b>4ys, 4mos, 7das</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital, Md.</b>		d. STREET ADDRESS <b>1208 Myrtle Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Henry</b> Last <b>Unknown</b>		4. DATE OF DEATH Month <b>3</b> Day <b>18</b> Year <b>1958</b>	
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>84 7 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-04-7461</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>			
4341 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>Chronic Brain Syndrome associated with Senile Brain Disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>---</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January</b> 19 <b>53</b> , to <b>March 18</b> 19 <b>58</b> , that I last saw the deceased alive on <b>March 18</b> 19 <b>58</b> , and that death occurred at <b>5:45 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		DATE SIGNED <b>3/19/58</b>	
PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Burial</b>		<b>3/24/58</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Mt. Auburn Cem.</b>		<b>Balti. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Harper</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 27 '58</b>	
ADDRESS <b>512 Pineview av</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
<b>Balti. Md.</b>			

BUREAU V. S.

MAR 27 1907

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

02754

2807

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kentucky</b> <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G Meade</b>				c. LENGTH OF STAY IN 1b <b>X Baltimore London</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Army Hospital</b>				d. STREET ADDRESS <b>1411 Shore Road Apt. 5 Box 131</b>			
3. NAME OF DECEASED (Type or print) First <b>INFANT MALE</b> Middle <b>HENSLEY</b> Last				4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 March 1958</b>		9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>1</b> Days <b>3</b> Hours <b>-</b> Min <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harold Hensley</b>				14. MOTHER'S MAIDEN NAME <b>Leona Hensley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)		16. SOCIAL SECURITY NO <b>-</b>		17. INFORMANT (Father) Address <b>Harold Hensley, 1411 Shore Road, Baltimore 20, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>776x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> DUE TO (c) <b>-</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Lifetime</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12 Mar</b> 19 <b>58</b> to <b>13 Mar</b> 19 <b>58</b> , that I last saw the deceased alive on <b>13 Mar</b> 19 <b>58</b> , and that death occurred on <b>0620 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. ARMY HOSPITAL, FT G G MEADE, MD</b> DATE SIGNED <b>13 Mar 1958</b>							
ACTUAL SIGNATURE <b>Frank L. Gruskay</b>				PHYSICIAN'S NAME (Type) <b>FRANK L. GRUSKAY, CAPT, MC</b> <b>U. S. ARMY HOSPITAL, FT G G MEADE, MD</b>			
22a. BURIAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Earl B Waberton</b>				24a. REC'D BY REGISTRAR DATE <b>13 Mar 58</b>		24b. REGISTRAR'S SIGNATURE <b>CLAUDE D. LAUSIER, CWO</b>	

6306 - Belair Rd, Baltimore - 6, Md

MAR 18 '58

A. W. Beach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MAR

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2808 CERTIFICATE OF DEATH

Reg. Dist. No.

02755

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G Meade, Md.</u>		c. LENGTH OF STAY IN 1b <u>8 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>US ARMY HOSPITAL, Ft Geo G. Meade, Md.</u>		d. STREET ADDRESS <u>7229 Martell Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Vera</u> Middle <u>L</u> Last <u>Hickman</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 March 1906</u>
9. AGE (In years last birthday) <u>52 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jessie Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Waller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Medium</u>		Address <u>U.S. Army Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purulent Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Septicemia, arising from staphylococcal infection of face</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>22 March</u> , 19 <u>58</u> to <u>30 March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>30 March</u> , 19 <u>58</u> , and that death occurred at <u>2:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Capt. Arnold D. Fiascone</u> M.D. <u>USAH - Ft. G. G. Meade</u>		DATE SIGNED <u>30 March 1958</u>	
PHYSICIAN'S NAME (Type) <u>ARNOLD D FIASCONE, Capt. MC U.S. Army Hospital, Ft. Meade, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Bradley</u>		ADDRESS <u>Durham, N.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>31 Mar 58</u>		24b. REGISTRAR'S SIGNATURE <u>CLAUDE D. LAUSIER, CWO, US</u>	

MEDICAL CERTIFICATION

2

THOMAS A. B.

APR 2 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2738

## CERTIFICATE OF DEATH

Reg. Dist. No.

02756

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b <b>77 Years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		d. STREET ADDRESS <b>86 Duke of Gloucester St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USNH ANNAPOLIS, MD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Elizabeth HILL</b>		4. DATE OF DEATH Month Day Year <b>MARCH 4 19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 March 1880</b>
9. AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR: Months Days Hours Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert E. SOMMERS</b>		14. MOTHER'S MAIDEN NAME <b>Arvilla WELLS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NA</b>		16. SOCIAL SECURITY NO. <b>NA</b>	
17. INFORMANT <b>USNH ANNAPOLIS, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>440x Congestive Heartfailure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 Weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 March</b> , 19 <b>58</b> , to <b>4 March</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4 March</b> , 19 <b>58</b> , and that death occurred at <b>8:15A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>USNH ANNAPOLIS MD.</b> DATE SIGNED <b>3-4-58</b>			
ACTUAL SIGNATURE <b>[Signature]</b> M.D.		22. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
PHYSICIAN'S NAME (Type) <b>M. J. MILLER LT MC USNR</b>		22a. REC'D BY REGISTRAR DATE <b>MAR 6 '58</b>	
22b. DATE THEREOF <b>3-7-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Naval Academy Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		24a. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

DELANO K. B.

MAR 1958

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

02757

2739

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>HISSEY</u> Last <u>HISSEY</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years and birthday) <u>about 64</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOAT YARD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Alonso Smith</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia, rt. mid-lobe</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>  </u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ch. Emphysema; Ch. Bronchectasis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/15</u> , 19 <u>58</u> , to <u>3/19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/19/58</u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Krawans</u> M.D.		ADDRESS (Street, city or town, state) <u>31 Southgate Dr Annapolis Md.</u>	
DATE SIGNED <u>3/22/58</u>		PHYSICIAN'S NAME (Type) <u>MAURICE F. KRAWANS</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-24-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>  </u>		DATE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 26 '58

RECEIVED

MAR 20 1959

BUREAU V. S.

CERTIFICATE OF DEATH

28-9

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>6 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1215 Wilson Road</u>				d. STREET ADDRESS <u>1215 Wilson Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Philip</u> <u>Sia</u> <u>---</u> <u>---</u>				4. DATE OF DEATH Month Day Year <u>---</u> <u>7</u> <u>19</u> <u>55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1877</u>		9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance (P.C.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>German</u>	
13. FATHER'S NAME <u>Phillip Dahle</u>				14. MOTHER'S MAIDEN NAME <u>Amelia (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. George Dahle</u> Address <u>same as 15</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>55</u> , to <u>Present</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb. 27</u> , 19 <u>55</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>H. F. Manuzak</u> M.D.				PHYSICIAN'S NAME (Type) <u>H. F. Manuzak</u> M.D. <u>21 Liberty Road, Glen Burnie Md. 21038</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 10, 1955</u>		<u>London Park Cem.</u>		<u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. S. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

U. S. A.

1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02759

2740

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>ARNOLD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>PINES ON THE SEVERN</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>A</b> Last <b>HOFFMAN</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1876</b>
9. AGE (In years last birthday) <b>81 yrs</b>		10. IF UNDER 1 YEAR Months <b>26</b> Days <b>19</b> Hours <b>58</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Helfrich</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Otter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Mrs Lawrence Rembold- Daughter- same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension - arteriosclerotic type</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> to <b>3-26-1958</b> , that I last saw the deceased alive on <b>3-25-1958</b> , and that death occurred at <b>7:59 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank M Shipley</b>		M.D. <b>3-29-59</b>	
PHYSICIAN'S NAME (Type) <b>Frank Shipley MD</b>		<b>63 College Ave Annapolis, Md.</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-31-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Maryland</b>	
24a. RECEIVED BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <b>W. Reed</b>	

BUREAU V. S.

APR 2

RECEIVED

FOR STATE  
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If last location, residence before admission) o STATE <u>Maryland</u> COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Cumbersstone</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Cumbersstone</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Washington</u> First <u>Hutton</u> Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1925</u>
9. AGE (In years, months, and days) <u>32</u> yrs		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>14</u> Hours <u>14</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Well Digger</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Hope Chapel</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harry Hutton</u>	
14. MOTHER'S MAIDEN NAME <u>Florence B. Brown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes</u> <u>World War II</u>	
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Henry Hutton</u> Address <u>Apt. B, Lyndale</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured skull</u> <u>823x</u> DUE TO (b) <u>multiple lacerations + contusions</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Passenger in automobile which struck a tree</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cumbersstone</u>		20f. (City or town) (County) (State) <u>A. A. Co. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Emil H. Wilson</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-18-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-19-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hope Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>idgewater Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #108</u>		ADDRESS <u>108 W. 1st St. Cumbersstone, Md.</u>	
24a. REC'D BY REGISTRAR <u>Rev. Seuch</u>		24b. REGISTRAR'S SIGNATURE <u>Rev. Seuch</u>	
DATE <u>MAR 24 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral par. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the funeral par. TO FUNERAL DIRECTOR: OR, Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 63-21-53 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

02761

2741

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>Davidsonville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CAROLINE HARRIETTE CARR IGLEHART</b>		4. DATE OF DEATH Month Day Year <b>March 14 1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1870</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Henry Carr</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Green</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>N.E. Berry Iglehart</b>		Address <b>Davidsonville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>156.1</b> <b>TRANSITION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC CARCINOMA OF LIVER</b> DUE TO (c) <b>6 months</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3/11</b> , 1958, to <b>3/14</b> , 1958, that I last saw the deceased alive on <b>3/13</b> , 1958, and that death occurred at <b>57</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Edward S. Beck</b> M.D. PHYSICIAN'S NAME (Type) <b>Edward S. Beck, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 17, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>All Hallows Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Davidsonville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 18 '58</b>	
ADDRESS <b>Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>	

BUREAU V. S.

MAR 18 1939

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2742

Item 9 1-1-2003-19-58 et

CERTIFICATE OF DEATH

02762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 Drew Street - Parole</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>Gilbert</u> Last <u>Isaacs</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14-1901</u>	9. AGE (In years last birthday) <u>56</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storage Clerk-U.S. Gov.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>		11. BIRTHPLACE (State or foreign country) <u>Parole-A.A.Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>
13. FATHER'S NAME <u>Stephen Isaacs</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Henderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Stephen Isaacs 1811 Robert Small Rd. Forest Vil</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour a. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u>		(County) <u>  </u>	(State) <u>  </u>
21. I certify that I attended the deceased from <u>1-27-58</u> 19 <u>  </u> to <u>3-2-58</u> 19 <u>  </u> , that I last saw the deceased alive on <u>2-26-58</u> 19 <u>  </u> and that death occurred at <u>11:00</u> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.T. Allen</u> M.D. <u>G.L. Cathedral</u>				ADDRESS (Street, city or town, state) <u>Cathedral Street Annapolis, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>A.T. Allen</u>				DATE SIGNED <u>3-3-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hick 111</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>			

U. S. A.

1918

1918

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give lloges 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 02763											
1. PLACE OF DEATH a. COUNTY <u>M. A. CO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P.A. gen. Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>St. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Curtis</u> Middle <u>Jackson</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1958</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 29 1938</u>		9. AGE (In years last birthday) <u>3 mos. 5 yrs.</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Hall</u>				14. MOTHER'S MAIDEN NAME <u>Blair Jackson</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Georgia Jackson</u>		Address <u>Severna Park</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>asphyxia</u> <u>921.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>after feeding aspiration of vomitus</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>3:10</u> <u>PM</u> p. m. <u>3:10</u> <u>PM</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Annapolis</u> (County) (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>E. L. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Mar. 28 1958</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Carpenter's Hill</u>		22d. LOCATION (City, town, or county) <u>Jones Station</u> (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson</u>				ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Richard</u>			

BOSTON, N. E.

MAR 2 1900

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2811

Reg. Dist. No. **02764**

**FOR STATE  
HEALTH DEPT.**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>1 year</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>60 Asington Rd. Harundale</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> <span style="float: right;">b. COUNTY <u>Same</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Walter Jerome Jackson</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March the 18th. 19 58</u>			
<b>5. SEX</b> <u>M.</u>		<b>6. COLOR OR RACE</b> <u>W.</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>5/19/85</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs		<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired employee from Proctor &amp; Gamble</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore, Md.</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Samuel Jackson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>FANNIE Thompson Johnson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>(If yes, give war or dates of service)</u>		<b>17. INFORMANT</b> Address <u>Mrs. Flora E. Cooper, (daughter)</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p><b>PART I. DEATH WAS CAUSED BY:</b></p> <p><b>IMMEDIATE CAUSE (a)</b> <u>Coronary Occlusion</u></p> <p><b>DUE TO</b></p> <p><b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b></p> <p><b>(b)</b> <u>Hypertension</u></p> <p><b>DUE TO</b></p> <p><b>(c)</b> _____</p> </div> <div style="width: 15%;"> <p><b>INTERVA. BETWEEN ONSET AND DEATH</b>  <u>Sudden</u></p> </div> </div> <p><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b></p>							
<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Gustave H. Faubert M.D.</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>					
<b>EXAMINER'S NAME (Type)</b> <u>Gustave H. Faubert M.D.</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>					
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>3/19/58</u>		<b>DATE SIGNED</b>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>March 22 1958</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cem.</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore 25 Md</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hopping &amp; Hickey</u>		<b>ADDRESS</b> <u>Ellen Burnie, Md</u>		<b>24a. REC'D BY REGISTRAR</b> <u>MAR 24 58</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Gustave H. Faubert</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 24 1959

U.S. AIR FORCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2744

CERTIFICATE OF DEATH

Reg. Dist. No.

02765

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>AIPIAP LIS</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>ARNOLD</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH HOFFMAN JACOBS</b>				4. DATE OF DEATH Month Day Year <b>MARCH 13 19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 21, 1876/1875</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Latria, Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Jacobs</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Hoffman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>738 Longfellow Rd Jack H. Jacobs N.W. Washington, D.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Broncho-Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>900.0</b> DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shattered Pelvis; Central Fracture - Dislocation L. hip</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>Slipped on icy steps</b>					
20c. TIME OF INJURY Hour a. m. p. m. <b>2:30 p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Annapolis, An. Md.</b>	
21. I certify that I attended the deceased from <b>Feb 11</b> , 19 <b>58</b> , to <b>Mar 13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>March 13</b> , 19 <b>58</b> , and that death occurred at <b>3:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>31 SOUTH GATE AVE ANNAPOLIS, MD</b> DATE SIGNED <b>3/14/58</b>							
ACTUAL SIGNATURE <b>Maurice F. Klawans</b>		PHYSICIAN'S NAME (Type) <b>MAURICE F. KLAWANS</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>3-14-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 17 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Paul...</b>	

BUREAU V

MAR 17 1930

RECEIVED

2745

## CERTIFICATE OF DEATH

Reg. Dist. 42766

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>76 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>				d. STREET ADDRESS <u>22 Cornhill St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Frederick JOHNS</u>				4. DATE OF DEATH Month Day Year <u>MAR 29 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 8, 1881</u>		9. AGE (In years last birthday) yrs. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas JOHNS</u>				14. MOTHER'S MAIDEN NAME <u>Lucy DARNILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>WWI 248-12-9148</u>		17. INFORMANT Address <u>U.S. Naval Hospital, Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-29</u> , 19 <u>58</u> , to <u>3-29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-29</u> , 19 <u>58</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>3-30-58</u>							
ACTUAL SIGNATURE <u>Frederick J. C. McSwain</u>				PHYSICIAN'S NAME (Type) <u>W. W. THOMAS LT MC USNR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-2-1958</u>		<u>Balto. National</u>		<u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beesett</u>				ADDRESS <u>108 Wash. St. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 2 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>Died</u>			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

10-11-1918

2746

## CERTIFICATE OF DEATH

02767

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <small>MARYLAND</small>		2. USUAL RESIDENCE (Where deceased lived) If institution residence before admission a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) FOR INSTITUTION <u>124 S. Villa Ave</u>		d. STREET ADDRESS <u>124 South Villa Ave</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>A</u> Middle <u>Johnson</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Lloyd R. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Harriett A. Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-2411A</u>	
17. INFORMANT <u>Mary Peterson</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>about 1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-11-58</u> , 19 <u>58</u> , to <u>3-6-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-1-58</u> , 19 <u>58</u> , and that death occurred at <u>7:15</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Lochford St</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		DATE SIGNED <u>3-7-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>W. Reese, Jr.</u>		24b. REGISTRAR'S SIGNATURE <u>W. Reese, Jr.</u>	
DATE <u>MAR 11 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNN V. S.

MAR 11 1913

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND-STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 2812 CERTIFICATE OF DEATH

Reg. Dist. No. 02768

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>Parkton. 0-1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PLAZA MANOR CONV. HOME</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>A.</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-1872</u>
9. AGE (In years full birthday) <u>86</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Co, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Jones.</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Riley.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Howard Davis, Parkton, Md. R.D.</u>		Address <u>Md. R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis general</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4-11-58</u> DUE TO (c) <u>1958</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cellulitis of leg</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 14, 1958</u> to <u>3-23, 1958</u> , that I last saw the deceased alive on <u>3-20</u> , 19 <u>58</u> , and that death occurred at <u>6:57</u> P.M. from the causes and on the date stated above.		DATE SIGNED <u>3-23-58</u>	
ACTUAL SIGNATURE <u>Joseph Taler, M.D.</u>		ADDRESS (Street, city or town, state) <u>102 Bd A. Blvd. M.E.</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH TALER, M.D. Glen Burnie, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>White Hall Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein</u>		ADDRESS <u>New Freedom, Pa</u>	
24a. REC'D BY REGISTRAR <u>W. Search</u>		24b. REGISTRAR'S SIGNATURE <u>W. Search</u>	
DATE <u>MAR 26 '58</u>			

RECEIVED

MAR 22 1968

BUREAU W. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEST GATE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEST GATE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LAURENCE AVE.</u>		d. STREET ADDRESS <u>LAURENCE AVE</u>	
3. NAME OF DECEASED (Type or print) <u>JO ANN</u> First <u>KELLY</u> Middle <u>KELLY</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-1945</u> 12 yrs.
9. AGE (In years last birthday) <u>12</u>		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min. <u>12</u>	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	11. BIRTHPLACE (State or foreign country) <u>Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JOHN KELLY</u>	
14. MOTHER'S MAIDEN NAME <u>EDITH CRIDER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>MRS. LUCILLE HALL</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd degree burn, entire body</u> <u>716.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>House fire</u>	
20c. TIME OF INJURY Month, Day, Year <u>11</u> Hour <u>---</u> p.m. <u>3/10</u> 19 <u>58</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Atco</u> (County) <u>Mo.</u> (State) <u>Mo.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. L. in hand</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. in hand</u>		DATE SIGNED <u>3/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>Mo.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Foy</u>		24a. REC'D BY REGISTRAR <u>---</u> 24b. REGISTRAR'S SIGNATURE <u>---</u>	
- ADDRESS <u>Annapolis, Md.</u>		DATE <u>MAR 26 '58</u>	

BUREAU K. S.

MAR 26 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2814

CERTIFICATE OF DEATH

Reg. Dist. No.

02770

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 34514</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>102 Bd A Blvd. M.E.</b>		d. STREET ADDRESS <b>6718 Glen Oak Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Harold T Lankford</b>		4. DATE OF DEATH <b>3 4 1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1897</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Mgr. Master Loan Company</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
10a. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		10b. CITIZEN OF WHAT COUNTRY <b>USA</b>	
11. FATHER'S NAME <b>J. Edgar Lankford</b>		12. MOTHER'S MAIDEN NAME <b>May M. Thomson</b>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>(1)</b>		14. SOCIAL SECURITY NO	
15. INFORMANT <b>Mrs. Lillian E. Lankford</b>		Address <b>6718 Glen Oak</b>	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20b. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-4</b> , 19 <b>58</b> , to <b>3-4</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3-3</b> , 19 <b>58</b> , and that death occurred at <b>3:30 P</b> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Joseph Taler</b> M.D.		ADDRESS (Street, city or town, state) <b>102 Bd A Blvd. M.E.</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH TALER, M.D.</b>		DATE SIGNED <b>3-4-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/8/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Hargord Road #14</b>	
24a. REC'D BY REGISTRAR <b>MAR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

ROBERT V. S.

MAR 7 1968

RECEIVED

2747

CERTIFICATE OF DEATH

02771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>AA Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL</u>				d. STREET ADDRESS <u>22 GUNNERY AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>REBECCA</u> Middle <u>LEVIN</u> Last <u>LEVIN</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 1982</u>	
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>EDWARD LEGUM</u>				14. MOTHER'S MAIDEN NAME <u>CECILIA SAVAL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>MRS MORRIS FELDMAN - DAUGHTER - SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/5</u> , 19 <u>58</u> , to <u>3/6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/6</u> , 19 <u>58</u> , and that death occurred at <u>2:40</u> AM, from the causes and on the date stated above							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Richard A. Peeler</u> M.D.				<u>68 FRANKLIN ST. 3/6/58</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>				<u>ANNAPOLIS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3-7-58</u>		<u>HNESETH ISRAEL</u>		<u>ANNAPOLIS, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Hopping</u> ADDRESS <u>HARRIS</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

MAR 11 1958

RECEIVED

2815

02772

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Aundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>				c. LENGTH OF STAY IN 1b <b>1 month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Walter</b> Last <b>Lewis</b>				4. DATE OF DEATH Month <b>3</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/1872?</b>	9. AGE (In years lost birthday) <b>85?</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>6</b> Hours <b>1958</b>		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>James Lewis</b>			
14. MOTHER'S MAIDEN NAME <b>Mae</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>-----</b>				17. INFORMANT <b>Hospital Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <b>Cardiovascular Disease</b> <b>422.1</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Incarcerated Hernia</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>			
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	
20f. (City or town) <b>-----</b>				20g. (County) <b>-----</b>		20h. (State) <b>-----</b>	
21. I certify that I attended the deceased from <b>February 5</b> , 19 <b>58</b> , to <b>March 6</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>March 6</b> , 19 <b>58</b> , and that death occurred at <b>5:15a</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Hildegard Heard Reissmann</b> M.D.				ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>		DATE SIGNED <b>3/6/58</b>	
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D.</b> <b>Crownsville State Hospital, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/10/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Ambrose</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore City Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holland Funeral Home 1631 David Hill Ave</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Lewis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TURNER V. S.

MAR 10 1905

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2816

CERTIFICATE OF DEATH

02773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Annie Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Annie Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>				c. LENGTH OF STAY IN 1b <b>11 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>			
				f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PAYTON</b> Middle <b>LEWIS</b> Last <b>LEWIS</b>				4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec-23-</b>	9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months <b>51</b> Days <b>16</b> Hours <b>16</b> Min.	IF UNDER 24 HRS Months <b>51</b> Days <b>16</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Essex County Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>William Lewis</b>				14. MOTHER'S MAIDEN NAME <b>Essie ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>Marie Lewis</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of Myocardium</b> DUE TO <b>Arteriosclerotic Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Ischemic Congestion</b> (c) <b>Ischemic Congestion</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct. 15, 1957</b> to <b>March 16, 1958</b> , that I last saw the deceased alive on <b>March 5, 1958</b> , and that death occurred at <b>1:30 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thos. Woolridge Sr</b>				ADDRESS (Street, city or town, state) <b>Box 212 Eldridge 27 Md</b>			
PHYSICIAN'S NAME (Type) <b>Thos. Woolridge MD</b>				DATE SIGNED <b>Mar 24 '58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-15-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Antebellum Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Severn Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thos. Wilson</b>				ADDRESS <b>1000 Bowley Ave</b>		24a. REC'D BY REGISTRAR <b>Mar 24 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>P. H. Beach</b>			

BUREAU V. S.

SEP 10 1903

RECEIVED

2817 **CERTIFICATE OF DEATH**

02774

Reg. Dist. No. ....

Item 2 Film Q227 3-31-58 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>11</u> City			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Green BURNIE</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 17</u>		3 Vol. 4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MAYOR CONV. HOME</u>				STREET ADDRESS (If rural give location) <u>2221 Callov Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>George</u> (First) <u>Lipscombe</u> (Middle) <u>Lipscombe</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Mar</u> (Day) <u>16</u> (Year) <u>1958</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> <u>67</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>Bonapart Lipscomb</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Caroline Lipscomb</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>2717 Gwynesfall Pkwy</u> <u>Geraldine Lipscomb</u>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis general</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>19. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, term, lecture, or INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M.		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Feb</u> , 19 <u>55</u> , to <u>3-16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-15</u> , 19 <u>58</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Joseph T. ...</u> M.D. <u>10203 A Blvd. N.E. Cal. Bldg. Apt. 316-4</u>				<b>DATE SIGNED</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Mar. 19, 1958</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mount Auburn Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Baltimore Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Mar 24 '58</u>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>MIROY O. WILSON</u> <b>ADDRESS</b> <u>1000 Brantley Av</u>			

INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M-1

THE UNIVERSITY OF CHICAGO

U.S. ARMY

1945

12-1-45

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2818

## CERTIFICATE OF DEATH

Reg. Dist. No. 02775

1. PLACE OF DEATH a. COUNTY <u>MD. 2. Prince George's</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt, Md.</u>		c. LENGTH OF STAY IN 1b <u>105.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt, Md.</u>		d. STREET ADDRESS <u>Rt. 6</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 6 Box 26</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Thomas Jones</u>		4. DATE OF DEATH Month Day Year <u>March 10, 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Industrial Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John K. White</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Carl Lower</u>		Address <u>Glen Burnie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>Coronary artery disease &amp; angina pectoris</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 years</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus, 1 year -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 15, 1958</u> to <u>March 28, 1958</u> , that I last saw the deceased alive on <u>March 21, 1958</u> , and that death occurred at <u>11:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>		DATE SIGNED <u>April 1, 1958</u>	
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>		<u>Jacobsville, Frederick Co., Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>Apr. 2, 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenbelt Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Greenbelt, Prince George's Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. S. Singleton</u>		ADDRESS <u>1010 E. Main St., Baltimore, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

U. S. A.

836

U. S. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2748

## CERTIFICATE OF DEATH

02776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE (HARUNDALE)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>		d. STREET ADDRESS <u>1233 Guilford Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy LUTZI</u>		4. DATE OF DEATH Month Day Year <u>March 10 19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-7-58</u>
9. AGE (In years last birthday) yrs		10. AGE (In years last birthday) yrs	
11. BIRTHPLACE (State or foreign country) <u>Annapolis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>PHILIP CHARLES LUTZI</u>		14. MOTHER'S MAIDEN NAME <u>GLORIA GLADYS MILLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>U.S.N. Hospital, Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>756.2</u> IMMEDIATE CAUSE (a) <u>INTESTINAL OBSTRUCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUODENAL ATRESIA</u> DUE TO (c) <u>---</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple congenital anomalies (hair lip complete, cleft palate, Atresia left kidney)</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-7-</u> , 19 <u>58</u> , to <u>3-8-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-8-</u> , 19 <u>58</u> , and that death occurred at <u>1203A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>James DePaola</u> M.D. <u>U.S.N. Hospital, Annapolis, Md.</u> <u>3-10-58</u> PHYSICIAN'S NAME (Type) <u>F.(n) DePaola LT MC USNR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		24a. REC'D BY REGISTRAR <u>---</u>	
24b. REGISTRAR'S SIGNATURE <u>---</u>		24c. DATE <u>MAR 12 '58</u>	

RECEIVED  
MAR 10 1953  
BUREAU V. S.

2819

## CERTIFICATE OF DEATH

02777

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Palapasco Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Palapasco Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>-</i>		d. STREET ADDRESS <i>1300 Berlin Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Marie</i> First <i>Lyons</i> Middle Last		4. DATE OF DEATH Month <i>March</i> Day <i>13</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>45</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>	
13. FATHER'S NAME <i>Tom Smith</i>		14. MOTHER'S MAIDEN NAME <i>Blanche</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Bernard Lyons</i>		Address <i>300 Berlin Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>			
33ix DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Vascular Disease</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cancer of Uterus</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12 Jan. 1958</i> to <i>13 March 1958</i> , that I last saw the deceased alive on <i>13 March 1958</i> , and that death occurred at <i>8:00 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Renold B. Lightston</i>		M.D. <i>501 Cherry Hill Row</i> DATE SIGNED <i>3/13/58</i>	
PHYSICIAN'S NAME (Type) <i>Renold B. Lightston, Jr.</i>		<i>Baltimore 25 M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3--17-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs. Frances A. Hemmley</i>		ADDRESS <i>575 W Biddle St.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Overseer</i>	
DATE <i>MAR 17 '58</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 17 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

02778

1. PLACE OF DEATH a. COUNTY <u>a a</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mid</u> b. COUNTY <u>a a</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>a. a. General Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Alphonzo</u> Last <u>Marshall</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/6/02</u>
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fishing Captain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing Boat Bldg</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD</u>	
13. FATHER'S NAME <u>Robert A. Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Rosa E Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216 18 5775</u>	
17. INFORMANT <u>Mary Edna Marshall Deale, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pancreatitis</u> <u>576x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute chemical peritonitis</u> DUE TO (c) <u>with secondary infection</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>576x</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/24</u> 19 <u>58</u> , to <u>March 9</u> 19 <u>58</u> , that I last saw the deceased alive on <u>March 9</u> 19 <u>58</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kithson, Md.</u> DATE SIGNED <u>3-11-58</u>			
ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D.		PHYSICIAN'S NAME (Type) <u>Kithson, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St James</u>	22d. LOCATION (City, town, or county) (State) <u>Tracy's Landing Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardaway Salisbury</u>		24. SEE TO BY REGISTRAR DATE <u>APR 1 4 58</u>	
25. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar's office.

RECEIVED  
MAR 14 1  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2820

## CERTIFICATE OF DEATH

Reg. Dist. No. 027770

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA-Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSP</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>L.</u> Last <u>MARTINES, SR.</u>		4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 17 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>61</u> Days <u>9</u> Hours <u>17</u> Min.	11. IF UNDER 24 HRS Months <u>61</u> Days <u>9</u> Hours <u>17</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FISHING BOATS</u>	
11. BIRTHPLACE (State or foreign country) <u>MAYO, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BOWIE MARTINES</u>		14. MOTHER'S MAIDEN NAME <u>WIBBIE MAE PURTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>577-12-3789</u>	
17. INFORMANT <u>Mrs. ALICE P. MARTINES - WIFE - #2</u>		Address <u>SAME AS</u>	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURE, RIGHT MIDDLE CEREBRAL ARTERY</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE + ARTERIOSCLEROTIC</u> DUE TO <u>CARDIOVASCULAR DISEASE</u> (c) <u>UNKNOWN.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/8</u> , 19 <u>58</u> , to <u>3/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/8</u> , 19 <u>58</u> , and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Peeler</u>		DATE SIGNED <u>3/9/58</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		<u>ANNAPOLIS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>3-12-58</u>	<u>MAYO MEMORIAL</u>	<u>MAYO, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPKINS</u>		ADDRESS <u>ANNAPOLIS, MD.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>MAR 11 1958</u>		<u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. BUREAU

MAR 11 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2821

## CERTIFICATE OF DEATH

Reg. Dist. No.

02780

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville and Life</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ann's Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dr Oscar McNamee</u>		4. DATE OF DEATH Month Day Year <u>3 21 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 26, 1872</u>
9. AGE (In years last birthday) yrs <u>85</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harrison McNamee</u>		14. MOTHER'S MAIDEN NAME <u>Lucretia Ann Ogg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-37-10000-1</u>	
17. INFORMANT <u>Mr. Thomas McNamee</u>		Address <u>Sovereign Park, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>Chronic Cardiac Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis + Senility</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1-56</u> to <u>March 21-58</u> , that I last saw the deceased alive on <u>March 19-58</u> and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Lipskey</u>		DATE SIGNED <u>3-21-58</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKEY</u>		<u>ODENTON, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 25, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Mem. Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Millersville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>W. Singleton</u>		24b. REGISTRAR'S SIGNATURE <u>W. Singleton</u>	

RECEIVED

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BUREAU U. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02781

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5303 Wasena Avenue</b>				e. STREET ADDRESS <b>5303 Wasena Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>EDWARD</b> Last <b>MEARS</b>				4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/21/57</b>		9. AGE (in years last birthday) yrs. <b>2</b> Months <b>22</b> Days <b>22</b>	10. IF UNDER 1 YEAR Months <b>2</b> Days <b>22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Moury Mears</b>				14. MOTHER'S MAIDEN NAME <b>Marceline Cooper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Moury Mears, 5303 Wasena Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Paul F. Guerin</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>3/13/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>3-14-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCurry Funeral Home</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>DATE MAR 17 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arch...</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N. 8

MAR 17 1958

RECEIVED

2750

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>16 Monroe Court</b>		d. STREET ADDRESS <b>16 Monroe Court</b>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>V</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>23</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1883</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retail store</b>	
11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David V. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Jennie T. Britton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>214-05-0243</b>	
17. INFORMANT <b>Mrs. Amy B. Miller- Wife- Same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerosis Generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 yr</b> <b>2 yr</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 15, 1957</b> to <b>March 23, 1958</b> , that I last saw the deceased alive on <b>March 22, 1958</b> , and that death occurred at <b>1:15</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James R. Martin</b>		DATE SIGNED <b>3/24/58</b>	
PHYSICIAN'S NAME (Type) <b>James R. Martin MD</b>		<b>8 Shaw Street Annapolis, Maryland</b>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-25-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hepping Funeral Home</b>		ADDRESS <b>Annapolis, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 1 - 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2751

CERTIFICATE OF DEATH

02783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			c. LENGTH OF STAY IN 16 <u>50 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH ANNAPOLIS, MD.</u>				d. STREET ADDRESS <u>195 Main</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Helen</u> Last <u>MILLER</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>14</u> Year <u>1958</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-18-07</u>		
9. AGE (In years last birthday) yrs. <u>50</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Grant LUCAS</u>				14. MOTHER'S MAIDEN NAME <u>Cora Muchella HUNT</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>  -  -  -  </u>		17. INFORMANT <u>USNH ANNAPOLIS, MARYLAND</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXIC HEPATITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE MYELOGENOUS LEUKEMIA</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Dec</u> , 19 <u>57</u> , to <u>14 Mar</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 Mar</u> , 19 <u>58</u> , and that death occurred at <u>8:08 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Anna. Md.</u> DATE SIGNED <u>3-15-58</u>								
ACTUAL SIGNATURE <u>[Signature]</u>			PHYSICIAN'S NAME (Type) <u>M. J. MILLER LT MC USNR</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-17-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEAR Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis</u> <u>Mo.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 58</u>		
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

BUREAU V. S.

MAR 10 1918

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2823

CERTIFICATE OF DEATH

02784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A.A.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A.A.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Orchard Beach</b>				c. LENGTH OF STAY IN lb <b>Orchard Beach</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Seabreeze Drive</b>				e. STREET ADDRESS <b>Seabreeze Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>HOWARD T.</b> Middle <b>MITCHELL</b> Last <b>SR.</b>				4. DATE OF DEATH Month <b>3</b> Day <b>13</b> Year <b>58</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/20/85</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Family Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>480X</b> DUE TO <b>3rd day Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Influenza</b> DUE TO <b>1 week</b> (c) <b>Diabetes</b> <b>1 yr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>March 5</b> , 19 <b>58</b> , to <b>3/13</b> , 19 <b>58</b> , that I lost s/he the deceased on <b>3/13</b> , 19 <b>58</b> , and that death occurred at <b>3:30 P.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. B. WHELTLE</b>		M.D. <b>1279 William</b>		ADDRESS (Street, city or town, state) <b>Balto 30 Md</b>		DATE SIGNED <b>9/15/58</b>	
PHYSICIAN'S NAME (Type) <b>C. B. WHELTLE</b>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>B</b>	22b. DATE THEREOF <b>3/17/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes - 130 E. Fort Avenue</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Quail</b>	

RECEIVED

MAR 17 1958

BUNNAY V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2 & 22b, Film G227, 4/2/58

2824

## CERTIFICATE OF DEATH

Reg. Dist. No.

02785

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Same Maryland COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sann's Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Rossetta</u> First Middle Last Rose T. Moncure				4. DATE OF DEATH Month Day Year March 29 19 58			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/29/77 1977	9. AGE (In years day birthday) yrs. 80	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William S. Tunnell				14. MOTHER'S MAIDEN NAME Julia L Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO 5-77 None 6036A			
17. INFORMANT Sann's Nursing Home Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular diseases.</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 years							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>March 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/15/58</u> , 19 <u>58</u> , and that death occurred at <u>7:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eustace K. Barber, M.D.</u>				ADDRESS (Street, city or town, state) <u>5 First Avenue S.E.</u>			
DATE SIGNED <u>3/29/58</u>							
PHYSICIAN'S NAME (Type) <u>Eustace H. Fairbank, M.D.</u> <u>Glen Burnies, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reinold Harduty</u>				ADDRESS <u>Galiville Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 2 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alb. Smith</u>			

BUREAU V. 3

APR 2 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2825

## CERTIFICATE OF DEATH

Reg. Dist. No.

02786

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVIERA BEACH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVIERA BEACH</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BAY DRIVE</u>		1d STREET ADDRESS <u>BAY DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>A.</u> Last <u>NORRIS</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 18, 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CANDY MAKER</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>EVA G. PASSAUER</u>		Address <u>RIVIERA BEACH, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO (c) <u>3 YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>56</u> , to <u>MARCH 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MARCH 6</u> , 19 <u>58</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u>		DATE SIGNED <u>3/7/58</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		ADDRESS (Street, city or town, state) <u>RIVIERA BEACH, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 10, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>		ADDRESS <u>4001 RITCHIE HWY</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>DATE</u>	

RECEIVED  
MAR 11 1963  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**2826 CERTIFICATE OF DEATH**

**02787**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>AA</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>7</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solley</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Solley</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Solley, Md.</u>		d. STREET ADDRESS <u>Box 36</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Eunice</u> Middle <u>Olafson</u> Last <u>Olafson</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>9</u> Year <u>1958</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12-17-99</u>
<b>9. AGE</b> (In years last birthday) <u>58</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>5</u> Days <u>8</u> Hours <u>0</u> Min <u>0</u>	<b>11. IF UNDER 24 HRS</b> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OKlahoma</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>OKlahoma</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>OKlahoma</u>	
<b>13. FATHER'S NAME</b> <u>unknown</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO</b> <u>-</u>	
<b>17. INFORMANT</b> <u>Family</u>		<b>Address</b> <u>Same</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> <u>433.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>auricular Fibrillation</u> DUE TO (c) <u>multiple emboli</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 weeks</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Arteriosclerotic Pericardio Vascular</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>None</u>		<b>20f. (City or town)</b> (County) (State) <u>Balto, Md.</u>	
<b>21. I certify that I attended the deceased from</b> <u>Dec 3, 1957</u> <b>to</b> <u>3-9-58</u> <b>that I last saw the deceased alive on</b> <u>3-5-58</u> <b>and that death occurred at</b> <u>7</u> <b>M.</b> <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) <u>1101 Oakley Street, Balto, Md.</u> <b>DATE SIGNED</b> <u>Mar 12 '58</u>			
<b>ACTUAL SIGNATURE</b> <u>Henry Summers</u> M.D.		<b>PHYSICIAN'S NAME</b> (Type) <u>H. G. Summers</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3-13-58</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Balton Hill Cem</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Balto, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>McElly Funeral Home</u>		<b>ADDRESS</b> <u>Balto</u>	
<b>24a. REC'D BY REGISTRAR</b> <u>DATE</u> <u>Mar 12 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Overman</u>	

RECEIVED  
MAR 3 1964  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2827

CERTIFICATE OF DEATH

02788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 BROOKLYN PARK - A.A. Co. - MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 - 7th Ave.</u>		d. STREET ADDRESS <u>1 102 - 7th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGIA</u> Middle <u>OWENS</u> Last <u>OWENS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 22 - 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WOLFORD</u>		14. MOTHER'S MAIDEN NAME <u>  </u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u>	
17. INFORMANT <u>CLARENCE OWENS - 102 - 7th Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>10 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCTOBER, 1956</u> , to <u>MAR 1, 1958</u> , that I last saw the deceased alive on <u>MAR 1, 1958</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5010 A Ritchie Hwy</u> DATE SIGNED <u>Baltimore 25 MD</u>			
ACTUAL SIGNATURE <u>Benjamin J. Jordan</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Baltimore 25 MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN Co</u>	22d. LOCATION (City, town, or county) <u>Acc</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>THOMAS J. KENNY Inc. 1600 Hollins St</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>		24c. REGISTRAR'S SIGNATURE <u>  </u>	

BURTON V. S.

MAR 6 1931

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2752

## CERTIFICATE OF DEATH

Reg. Dist. No. 02789

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silverna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. Allen Hospital</u>				1. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sedonia</u> First Middle Last <u>Pack</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>color</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 20 1891</u>		9. AGE (In years last birthday) <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Robinson</u>		12. CITIZEN OF WHAT COUNTRY? <u>3</u>	
13. FATHER'S NAME <u>Thomas Butler</u>				14. MOTHER'S MAIDEN NAME <u>Lena Miles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1-3-58</u> 19 to <u>3-17-58</u> 19, that I last saw the deceased alive on <u>3-17-58</u> 19, and that death occurred at <u>8:50</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. T. Allen</u>				M.D. <u>G. L. Cothran</u>		DATE SIGNED <u>3-18-58</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>				<u>Annapolis Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Mar. 20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Towneak</u>		22d. LOCATION (City, town, or county) (State) <u>Silverna Park Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson</u>				ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 21 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2828

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> <b>New York</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft. George G. Meade</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessups Yonkers</b>		69X-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>				d. STREET ADDRESS <b>201 Oak Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DIANE</b> Middle <b>IRMA</b> Last <b>PARADISO</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 Jan 1958</b>		9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b>	IF UNDER 24 HRS. Hours <b>4</b> Min <b>1</b>
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eugene Paradiso</b>				14. MOTHER'S MAIDEN NAME <b>Irma Jaszczurski</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT (Father) <b>Eugene Paradiso, Box 2, Linden Apts, Jessups, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory failure</b> <b>756.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>electrolyte imbalance</b> DUE TO (c) <b>duodenal stenosis and duodenal band</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs - 4 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>malrotation, midgut volvulus, duodenal band.</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9 Feb</b> , 1958, to <b>4 Mar</b> , 1958, that I last saw the deceased alive on <b>13 Mar</b> , 1958, and that death occurred at <b>3:30 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. ARMY HOSPITAL FT MEADE, MD</b> DATE SIGNED <b>4 Mar 58</b>							
ACTUAL SIGNATURE <b>Samuel D. Gaby</b>				M.D. U. S. ARMY HOSPITAL FT MEADE, MD			
PHYSICIAN'S NAME (Type) <b>SAMUEL D. GABY, MD</b>				U. S. ARMY HOSPITAL FT MEADE, MD			
22a. BURIAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Carl B. Woberton</b>				ADDRESS <b>Funeral Home, Inc</b>		24a. REC'D BY REGISTRAR <b>CLAUDE D LAUSIER, CWO</b>	
DATE <b>4 Mar 58</b>				24b. REGISTRAR'S SIGNATURE <b>CLAUDE D LAUSIER, CWO</b>		DATE <b>4 Mar 58</b>	

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## Reg. Dist. No.

02790

1. PLACE OF DEATH a. COUNTY <u>AA</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AA General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leon</u> Middle <u>Parker</u> Last <u>JR</u>		4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/1957</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	IF UNDER 24 HRS Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Lothian Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>—</u>		13. FATHER'S NAME <u>Leon Parker</u>	
14. MOTHER'S MAIDEN NAME <u>Josephine Powers</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>—</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>3-22</u> , 19 <u>58</u> , to <u>5-22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-22</u> , 19 <u>58</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 SHAW ST, ANNAPOLIS, MD.</u> DATE SIGNED <u>3/28/58</u>			
ACTUAL SIGNATURE <u>JAMES R. MARTIN</u> M.D.		PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/22/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Adams</u>		22d. LOCATION (City, town, or county) (State) <u>Lothian MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hardisty Salvo</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Willie Smith</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2825 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04163

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>B. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>B. A. County</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Brewery Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brewery Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brewery Maryland</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Sadie Powell</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Chl</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-1900</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>31</u> Hours <u>19</u> Min. <u>58</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cook</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Cook</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Alexander Powell Brewery Md</u>	
17. INFORMANT <u>Alexander Powell Brewery Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial failure</u>		CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) <u>coronary artery occlusion</u>	
(c) <u>coronary arteriosclerosis</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Dr. H. H. H. H.</u>		DATE SIGNED <u>4-1-58</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-5-1958</u>	<u>Moses Cemetery</u>	<u>Brewery Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<u>William H. H. H.</u>		DATE <u>APR 1 0 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
<u>10820 Washington Ave. Md.</u>		<u>Q. Lewis</u>	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HAZEL</b> Middle <b>G</b> Last <b>PURDHAM</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>30</b> Year <b>58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 21, 1913</b>	
9. AGE (In years last birthday) <b>45</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Severn, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13. FATHER'S NAME <b>Henry C. Knight</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Christopher Purdham- Husband- same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 Hrs</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 1955</b> to <b>Mar 30, 1958</b> , that I last saw the deceased alive on <b>Mar 27, 1958</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward G. Skeritt</b>				ADDRESS (Street, city or town, state) <b>Gambrills, Md</b>			
DATE SIGNED <b>3-31-58</b>							
PHYSICIAN'S NAME (Type) <b>Edward Skeritt MD</b>				<b>Gambrills, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-2-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 3 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 7 1964

APR 7 1964

APR 7 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Their plates remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2755 CERTIFICATE OF DEATH

Reg. Dist. No.

02791

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>A.A. GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>M.</u> Middle <u>PURDIE</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>77</u> Days <u>14</u> Hours <u>1958</u>	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROFESSOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COLLEGE (U.S.U.A)</u>	
11. BIRTHPLACE (State or foreign country) <u>Mexico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Alexander Purdie</u>		14. MOTHER'S MAIDEN NAME <u>G. Hoover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MAYME B. PURDIE</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 3/13</u> , 19 <u>57</u> , to <u>3/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>58</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Peller</u> M.D.		ADDRESS (Street, city or town, state) <u>68 Franklin St Annapolis, Md.</u> DATE SIGNED <u>3/15/58</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PELLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U.S. NAVAL ACADEMY</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lynch &amp; Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAR 19 58</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>			

BUREAU V. S.

MAR 19 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2756

CERTIFICATE OF DEATH

02792

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		e. STREET ADDRESS <u>Camp Lett Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Henrietta Randall</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Butler</u>		14. MOTHER'S MAIDEN NAME <u>Lubenia Watkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>170</u>	
17. INFORMANT <u>William Brown - Balto. Md.</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>IX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-4-58</u> to <u>3-15-58</u> , that I last saw the deceased alive on <u>3-15-58</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>AT Allen</u> M.D.		DATE SIGNED <u>3-17-58</u>	
PHYSICIAN'S NAME (Type) <u>AT ALLEN</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-19-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stopes Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Edgewater, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annap. Md.</u>		24a. REC'D BY REGISTRAR <u>March 18 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Allen</u>	

BUREAU V. S.

MAR 19 1950

RECEIVED

2757

## CERTIFICATE OF DEATH

Reg. Dist. No.

02793

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNAPOLIS</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
c. LENGTH OF STAY IN 1b <u>3 days</u>				d. STREET ADDRESS <u>107 Independence Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNAPOLIS HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Ryan</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1925</u>		9. AGE (In years last birthday) <u>33</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed (1945-)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ryan</u>				14. MOTHER'S MAIDEN NAME <u>Bridgett Gibney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>169-01-4095</u>		17. INFORMANT <u>Mrs. Marie A. Thomas</u>		Address <u>Same as #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chr. Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Nephritis</u> DUE TO (c) <u>Chronic Nephritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>yes.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old Cerebral Thrombosis &amp; st. hemiplegia. Aneurysmal Fibillation</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/26</u> , 19 <u>58</u> , to <u>3/29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/28</u> , 19 <u>58</u> , and that death occurred at <u>10:05 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Maurice F. Krawans</u> , M.D.				ADDRESS (Street, city or town, state) <u>31 Santa Catalina Ave. Annapolis, Md.</u>		DATE SIGNED <u>3/29/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hume</u> ADDRESS <u>107 Independence Ave. Annapolis, Md.</u>							
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
DATE <u>APR 1 '58</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR

41

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2758

## CERTIFICATE OF DEATH

02794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville, RFD</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1st General Hos</u>				d. STREET ADDRESS <u>Millersville, RFD</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>A.</u> Last <u>HOUSING, JR.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1910</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Collison Lumber Elevator, Inc.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John A. Housing, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Alverta M. Housing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>1-11-111111</u>		17. INFORMANT <u>William D. Oldham, M.D.</u> Address <u>98 Cathedral St Annapolis Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> DUE TO <u>Carcinoma of bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 weeks approx</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month <u>Dec</u> Day <u>18</u> Year <u>1958</u> Hour <u>10</u> a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>Dec 18, 1958</u> to <u>March 5, 1958</u> , that I last saw the deceased alive on <u>March 5, 1958</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William D. Oldham M.D.</u>				ADDRESS (Street, city or town, state) <u>98 Cathedral St Annapolis Md</u> DATE SIGNED <u>March 6 1958</u>			
PHYSICIAN'S NAME (Type) <u>William D. Oldham</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>		22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>EAR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Earl</u>	

FURNACE W. S.

DECEMBER 1941

2759

## CERTIFICATE OF DEATH

Reg. Dist. No. 02795

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 180</b>		c. LENGTH OF STAY IN 1b <b>15 180</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Gambrills</b>	
		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>(Newborn - unnamed)</b>		4. DATE OF DEATH Month Day Year <b>March 15 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1958</b>
		9. AGE (In years last birthday) yrs. <b>10</b>	IF UNDER 1 YEAR Months Days <b>10 52</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	11. BIRTHPLACE (State or foreign country) <b>U. S.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>James Ridgley</b>		14. MOTHER'S MAIDEN NAME <b>Alicia Queen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Mother</b>	
17. INFORMANT <b>Gambrills, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atalectasis</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prematurity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 14, 1958</b> to <b>Mar. 15, 1958</b> , that I last saw the deceased alive on <b>Mar. 15, 1958</b> , and that death occurred at <b>9:30A M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Riley, Jr.</b>		ADDRESS (Street, city or town, state) <b>69 Franklin St., Annapolis, Md.</b>	
DATE SIGNED <b>Mar. 17 1958</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Robert A. Riley, Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Mar. 17 1958</b>		22b. DATE THEREOF <b>Mar. 17 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Tabot</b>		22d. LOCATION (City, town, or county) (State) <b>Chesterfield Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Johnson</b>		ADDRESS <b>Annapolis</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 19 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 17 1909

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE, 18

## 2760 CERTIFICATE OF DEATH

Reg. Dist. No.

02796

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b <b>ANNAPOLIS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S.N.H. ANNAPOLIS, MD.</b>		d. STREET ADDRESS <b>#4 OKLAHOMA TERRACE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ettie Catherine ROBBINS</b>		4. DATE OF DEATH Month Day Year <b>March 12 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 Jan 1910</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>	
11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Dennis Orville LOCKMAN</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Margarett WILLIAMS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>U.S.N.H. ANNAPOLIS, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Artery Thrombosis</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastases, mediastinum</b> DUE TO (c) <b>Carcinoma, urinary bladder</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 Mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11 Mar 1958</b> to <b>12 Mar 1958</b> , that I last saw the deceased alive on <b>12 Mar 1958</b> , and that death occurred at <b>3:35P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter M. Weber</b>		DATE SIGNED <b>U.S.N.Hosp. Annapolis, Md. 3-13-58</b>	
PHYSICIAN'S NAME (Type) <b>CAPT. W.M. WEBER MC USN</b>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-18-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Saylor</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 17 '58</b>	
ADDRESS <b>Annapolis Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Ch...</b>	

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MAR 17 1958

BUREAU V. S.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in blank in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

20 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 2, 8, 9, 10b, 11, 12, 13, 14 Film 226 3-26-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>16 Carver Apts. Crownsville State Hospital</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>ROSS</b> Last <b>ROSS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 28, 1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>William Ross</b>		14. MOTHER'S MAIDEN NAME <b>Nannie (maiden name unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Address</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary sclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>---</b> (c) <b>---</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>---</b> a. m. <b>19</b> p. m. <b>---</b> Month, Day, Year <b>---</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>
20f. (City or town) <b>---</b>		(County) <b>---</b> (State) <b>---</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED <b>3/3/58</b>		

22a. BURIAL CREMATION, REMOVAL (Specify) <b>1/14/58</b>	22b. DATE THEREOF <b>1/14/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Crownsville</b>	22d. LOCATION (City, town, or county) <b>Crownsville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Russell S. Fisher</b>	24a. REC'D BY REGISTRAR <b>---</b>	24b. REGISTRAR'S SIGNATURE <b>---</b>	DATE <b>MAR 18 '58</b>

RECEIVED  
MAR 18 1958  
BUREAU V. S.

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. page 3 should be filed far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

Items 11, 12, 22a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

03069

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - LAKE SHORE</b>		c. LENGTH OF STAY IN 1b <b>11 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LAKE SHORE DRIVE</b>		d. STREET ADDRESS <b>LAKE SHORE DRIVE</b>	
3. NAME OF DECEASED (Type or print) <b>RUTH LORETTA</b> First Middle Last		4. DATE OF DEATH <b>MARCH 31 1958</b> Month Day Year	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1893</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
12. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Turner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT Address</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO <b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2 YEARS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY</b> , 1957, to <b>MARCH 31, 1958</b> , that I last saw the deceased alive on <b>3/29</b> , 1958, and that death occurred at <b>10:00 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Brady Smith</b> M.D.		ADDRESS (Street, city or town, state) <b>Riviera Beach, Maryland</b> DATE SIGNED <b>3/31/58</b>	
PHYSICIAN'S NAME (Type) <b>J. BRADY SMITH</b>		<b>RIVIERA BEACH, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-2-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McLully Funeral Home</b> ADDRESS		24a. REC'D BY REGISTRAR <b>APR 3 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Alb...</b>	

APR 7 1950

RECEIVED  
FBI - NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02798

2832

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>				c. LENGTH OF STAY IN 1b <b>19ys3mos,27da</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital, Md.</b>				d. STREET ADDRESS <b>405 N. Potomac Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Sallie</b> Middle <b>Saunders</b> Last <b>Saunders</b>				4. DATE OF DEATH Month <b>3</b> Day <b>13</b> Year <b>19 58</b>			
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years lost birthday) <b>66</b> yrs	IF UNDER 1 YEAR Months <b>13</b> Days <b>19</b> Hours <b>58</b>		IF UNDER 24 HRS Months <b>13</b> Days <b>19</b> Hours <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>John Phoenix</b>			
14. MOTHER'S MAIDEN NAME <b>Mary E. Gillis</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-----</b>			
16. SOCIAL SECURITY NO. <b>-----</b>				17. INFORMANT <b>Hospital Records</b> Address <b>-----</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442x</b> DUE TO <b>Hypostatic Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Arteriosclerotic Cardiovascular Renal Disease</b> DUE TO (c) <b>-----</b>							INTERVAL BETWEEN ONSET AND DEATH <b>-----</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility, Dehydration, Decubitus Ulcers, Right Hemiplegia</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>-----</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>-----</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	
20f. (City or town) <b>-----</b>				20g. (County) <b>-----</b>		20h. (State) <b>-----</b>	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>56</b> , to <b>March 13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>March 13</b> , 19 <b>58</b> , and that death occurred at <b>10:26pm</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>3/14/58</b>							
ACTUAL SIGNATURE <b>Ludwig Benedict, M. D.</b>				PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>3-17-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. of Md. Wash. School</b>	
22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>				22e. (State) <b>Md.</b>		22f. (Country) <b>U.S.A.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W M Reese</b>				23b. ADDRESS <b>108 W Wash St</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 18 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Reese</b>				24c. (City, town, or county) <b>Baltimore, Md.</b>			

BUREAU V. S.

MAR 19 1938

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2761

## CERTIFICATE OF DEATH

02799

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>3 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOA Anne Arundel Gen. Hospital</u>				e. STREET ADDRESS <u>RT 4, BX 132, CAPE ST. CLAIRE</u>			
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>SCHMICK</u> Last <u>SCHMICK</u>				4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/1870?</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min. <u>86</u>	IF UNDER 24 HRS. Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min. <u>86</u>	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AUSTRIA</u>				13. FATHER'S NAME <u>John Schmick</u>			
14. MOTHER'S MAIDEN NAME <u>Theresa Rusk</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>3/18</u> , 19 <u>58</u> , to <u>3/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/18</u> , 19 <u>58</u> , and that death occurred at <u>4:50</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D.				ADDRESS (Street, city or town, state) <u>68 Franklin St., Annapolis, Md.</u>			
DATE SIGNED <u>3/20/58</u>				PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) <u>Kittlingbury, Glen Haven Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Fink</u> ADDRESS <u>Glen Haven Md</u>				24a. REC'D BY REGISTRAR <u>24 MAR 24 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. M. ...</u>	

MEDICAL CERTIFICATION

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2833

## CERTIFICATE OF DEATH

Reg. Dist. No.

02800

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLYN</b>		c. LENGTH OF STAY IN 1b <b>720.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5111 KRAMMIE AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AUGUST</b> Middle <b>Carl</b> Last <b>Schulz</b>		4. DATE OF DEATH Month <b>7</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5 - 1902</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>8</b> Hours <b>10</b> Min <b>10</b>	11. IF UNDER 24 HRS Months <b>5</b> Days <b>8</b> Hours <b>10</b> Min <b>10</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pa.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Pa.</b>	
13. FATHER'S NAME <b>AUGUST Schulz</b>		14. MOTHER'S MAIDEN NAME <b>Han Schindelhut</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>FAMILY</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelonephritis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>4 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>10</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/11/58</b> to <b>3/10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/10</b> , 19 <b>58</b> , and that death occurred at <b>6:35</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sidney R. Schlerf</b> M.D.		ADDRESS (Street, city or town, state) <b>4700 Pennington Ave.</b> DATE SIGNED <b>3/11/58</b>	
PHYSICIAN'S NAME (Type) <b>Sidney R. Schlerf M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>3-15</b>	<b>Southside Cem.</b>	<b>Pittsburg Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes</b>		ADDRESS <b>130 E. Fort Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Doel</b>	

BUREAU V. S.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04167

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>A. A. County</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside Md</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION, (If not in hospital, give street address) <u>Shadyside Md</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside Maryland</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>William</u> First <u>Scott</u> Middle Last		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>30</u> Year <u>1958</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Col.</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>12-4-1873</u>		<b>9. AGE</b> (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>owning and farming</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farmer</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Thomas Scott</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ann Cross</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>Wilson Scott Shadyside Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>uremia, ?</u> (a), stating the underlying cause last, DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of Item 18.)	
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>Emily H. Wilson</u> <b>EXAMINER'S NAME</b> (Type)		<b>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></b> <b>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></b> <b>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></b>	
<b>22a. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>4-3-1958</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Matthews</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Shadyside Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William Beeseth</u>		<b>24a. REC'D BY REGISTRAR</b> <u>4-1-58</u>	
<b>ADDRESS</b> <u>108 Wash St. Annapolis</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: For: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

PR 11 1969

BURNHAM V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2762

## CERTIFICATE OF DEATH

Reg. Dist. No.

02801

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>10</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USNH Annapolis, Md.</b>				d. STREET ADDRESS <b>123 Severn Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Katharine Sophie SEEBOHM</b>				4. DATE OF DEATH Month Day Year <b>Mar. 13 1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-20-72</b>	9. AGE (In years last birthday) yrs. <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Henry C. MATZEN</b>				14. MOTHER'S MAIDEN NAME <b>Katherine M. Giles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>No</b>		17. INFORMANT <b>USNH.</b> Address <b>ANNAPOLIS, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis right coronary artery</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Annapolis</b>		(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>3-10</b> , 19 <b>58</b> , to <b>3-13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3-12</b> , 19 <b>58</b> , and that death occurred at <b>12:40A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S.N. Hosp. Annapolis, Md.</b> DATE SIGNED <b>3-13-58</b> ACTUAL SIGNATURE <b>Walter M. Weber</b> M.D.							
PHYSICIAN'S NAME (Type) <b>CAPT W. M. WEBER MC USN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-16-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Annes</b>		22d. LOCATION (City, town, or county) <b>Annapolis</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sons</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Paul...</b>	

BUREAU V. S.

MAR 17 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 of the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

2835 CERTIFICATE OF DEATH

Reg. Dist. No. 02802

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>		c. LENGTH OF STAY IN 1b <u>5 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>	
		d. STREET ADDRESS <u>BROOKFIELD RD. Rt 8 Box 67</u>	
3. NAME OF DECEASED (Type or print) <u>FRANCES</u> First <u>—</u> Middle <u>SHEMENSKI</u> Last		4. DATE OF DEATH <u>MARCH 25</u> Month <u>1958</u> Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 11 1884</u>
9. AGE (In years lost birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH</u> <u>KWASNY</u>		14. MOTHER'S MAIDEN NAME <u>ROSALIE</u> <u>SETER</u> ( <u>SETHCK</u> )	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HELEN SHEMENSKI</u> Address <u>PASADENA</u> <u>BROOKFIELD RD.</u> <u>MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>NEPHRITIS, VASCULAR</u> (c) <u>HODGKINS DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>21 DAYS</u> <u>3 MO.</u> <u>12 MO.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 6</u> , 1958, to <u>MAR. 25</u> , 1958, that I last saw the deceased alive on <u>MAR 23</u> , 1958, and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur Lankford Jr</u>		ADDRESS (Street, city or town, state) <u>Mountain Rd. Pasadena Md.</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>		DATE SIGNED <u>MAR 25 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-29-58</u>		22b. DATE THEREOF <u>3-29-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>PA 110</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCurly Funeral Home</u>		24a. REC'D BY REGISTRAR <u>MAR 28 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Albrecht</u>	

BUREAU V. 3

1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 92 hours after death.

2836

CERTIFICATE OF DEATH

Reg. Dist. No.

02803

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A. A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Edgewater, Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bruce</u> First <u>Smith</u> Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 4, 1956</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Smith</u>		14. MOTHER'S MAIDEN NAME <u>Helen Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Helen Smith Edgewater Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Tracheo bronchitis</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-3</u> , 19 <u>58</u> , to <u>3-4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-3</u> , 19 <u>58</u> , and that death occurred at <u>10:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Faye W. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Cathedral St Annapolis</u> DATE SIGNED <u>3-5-58</u>	
PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>		<u>62 Cathedral St Annapolis Md</u> <u>3-5-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-7-1958</u>	<u>Moses Cemetery</u>	<u>Lincoln Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beesett</u> ADDRESS <u>108 Wash St Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Beesett</u>

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02804

2763

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>Harold Harbor</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>R</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>11</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 18, 1898</b>
9. AGE (In years last birthday) <b>59</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>Danville, Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Ralph Middleton</b>		14. MOTHER'S MAIDEN NAME <b>Cathering Burns</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>no</b>	
17. INFORMANT <b>Mr. William G. Smith - Husband - same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary heart disease; diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/2</b> , 19 <b>58</b> , to <b>3/11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/11</b> , 19 <b>58</b> , and that death occurred at <b>2:30</b> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John L. Hedeman</b>		DATE SIGNED <b>3/14/58</b>	
PHYSICIAN'S NAME (Type) <b>John Hedeman MD</b>		<b>Annapolis, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 15, 58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial Cemot.</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 17 '58</b>	
ADDRESS <b>Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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x

BUREAU A

MAR 17 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2837

CERTIFICATE OF DEATH

Reg. Dist. No.

02805

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>225 Doris Ave.</u>				d. STREET ADDRESS <u>225 Doris Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vera</u> Middle <u>Frances</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21, 1912</u>	
9. AGE (In years last birthday) <u>45</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Franklin Kohlhafer</u>				14. MOTHER'S MAIDEN NAME <u>Verna Narvell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Family</u> Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerotic cordiell</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 1953</u> to <u>Feb. 1958</u> , that I last saw the deceased alive on <u>February 18 1958</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eugene Schnitzer</u>				ADDRESS (Street, city or town, state) <u>3904 S. HANOVER ST.</u>		DATE SIGNED <u>3-13-58</u>	
PHYSICIAN'S NAME (Type) <u>Eugene Schnitzer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>				ADDRESS <u>Baltimore Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 17 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dee Beach</u>			

RECEIVED

MAR 17 1955

BUREAU Y

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VS A15 (4)  
15M 10/57

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02806

2764

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b> c. LENGTH OF STAY IN 1b <b>ANNAPOLIS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>174 West Street</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>174 West Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>EVA SODENSKY</b>		4 DATE OF DEATH Month Day Year <b>MARCH 22 19 58</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept 20, 1891</b>
9 AGE (In years last birthday) <b>66 yrs.</b>		10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11 BIRTHPLACE (State or foreign country) <b>Russia</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Unknown</b>		14 MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>213-34-8534</b>	
17. INFORMANT <b>Mr. Paul Sedensky- Son - Same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia &amp; Chronic Congestive failure</b> DOE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Diabetes M.</b> DOE TO <b>Diabetic gangrene, rt. foot</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic gangrene, rt. foot</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b> <b>many yrs.</b> <b>" "</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-6-55</b> to <b>3-22-58</b> , that I last saw the deceased alive on <b>3-22-58</b> , and that death occurred at <b>4:30 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank M Shipley</b>		ADDRESS (Street, city or town, state) <b>63 College Ave. Annapolis, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Frank Shipley MD</b>		DATE SIGNED <b>3-24-58</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-24-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Kneseth Israel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. A. ...</b>	

BUREAU V. E.

MAR 27 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2838

CERTIFICATE OF DEATH

Reg. Dist. No. 02807

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD (Sunset Knoll)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (RFD) Sunset Knoll</u>	
c. LENGTH OF STAY IN 1b <u>15 yrs</u>		d. STREET ADDRESS <u>Bridge Road - Rt. 5 - Box 61</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bridge Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Karl Steidinger</u> First Middle Last		4. DATE OF DEATH <u>March 26, 1958</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-17-1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown) Steidinger</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Sigrist</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>216-07-8160</u>	
17. INFORMANT <u>M. Alwin Ohler</u>		Address <u>2804 Summit Ave, Balto #39, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH
(b) <u>Carcinoma of the Sigmoid</u> DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 24-55</u> , 19 <u>55</u> , to <u>March 26, 1958</u> , that I last saw the deceased alive on <u>3-24-55</u> , 19 <u>55</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles R. MacDonald</u> M.D.		DATE SIGNED <u>3-27-58</u>	
PHYSICIAN'S NAME (Type) <u>Charles R. MacDonald</u>		<u>Glen Burnie, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 29, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>
DATE <u>MAR 31 '58</u>			

RECEIVED  
MAR 1968  
U. S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2765

CERTIFICATE OF DEATH

02808

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>430 SECOND ST.</u>		d. STREET ADDRESS <u>430 SECOND ST.</u>	
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>W. THOMAS</u> Middle <u>THOMAS</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-1896</u>
9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N.A. Ret.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ROBERT W. THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>IDA DAVIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WAT</u>	
17. INFORMANT <u>EDNA M. THOMAS</u> Address <u>#2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Cardio-Vascular</u> DUE TO <u>Disease</u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 <u>58</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 24, 1958</u> to <u>March 27, 1958</u> that I last saw the deceased alive on <u>March 27, 1958</u> and that death occurred at <u>2:20</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert L. Anderson</u> M.D.		ADDRESS (Street, city or town, state) <u>44 Southgate Ave - Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT L. ANDERSON</u>		DATE SIGNED <u>3/27/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-30-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Layton &amp; Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 31 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>

MEDICAL CERTIFICATION

STANTON V. S.

MAR

REC-101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2839

## CERTIFICATE OF DEATH

02809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville Md.</u>		c. LENGTH OF STAY IN 1b <u>7 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANN'S-Nursing-Home</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Tomanio</u> Last <u></u>			4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1958</u>		
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1904</u>	9. AGE (In years last birthday) yrs. <u>53</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Woman + Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
13. FATHER'S NAME <u>F. HANK HENDERSHOT</u>			14. MOTHER'S MAIDEN NAME <u>NETTIE SMITH</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>136-12-6335</u>		17. INFORMANT Name <u>Mary V. Sann.</u> Address <u>Acad Rd. Millersville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bilateral Hemiplegia</u> DUE TO (c) <u>Multiple Sclerosis - Generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Multiple Sclerosis - Generalized</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month <u>1</u> Day <u>19</u> Year <u>1958</u> Hour a. m. <u>7</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
21. I certify that I attended the deceased from <u>Dec 3-57</u> , 19 <u>57</u> to <u>March 21-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 17-58</u> , and that death occurred at <u>Home</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Acad Rd. Millersville</u> DATE SIGNED <u>3-22-58</u> ACTUAL SIGNATURE <u>DR. JOSEPH LIPKIN</u> PHYSICIAN'S NAME (Type) <u>ODONTON, MARYLAND</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping + KIRKLEY</u>		ADDRESS <u>1001 Burnie Rd</u>		24a. REC'D BY REGISTRAR DATE <u>March 26 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>					

RECEIVED

MAR 2 1961

BUCHANAN, A. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02810

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>H.A. Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>H.A. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BEST GATE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BEST GATE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>LAURENCE AVE.</b>		e. STREET ADDRESS <b>LAURENCE AVE</b>	
3. NAME OF DECEASED (Type or print) First <b>JUDY</b> Middle <b>ANN</b> Last <b>TUCKER</b>		4. DATE OF DEATH Month <b>3</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-8-1953</b>
9. AGE (In years and birthdate) <b>4</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>12</b> Hours <b>15</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>NORMAN J. TUCKER</b>		14. MOTHER'S MAIDEN NAME <b>EDITH CRIDER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>MRS. Lucille Habb</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3rd degree burn severe body</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO (c) <b>---</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Seconds</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>burn fire</b>	
20c. TIME OF INJURY Hour <b>11:44</b> a.m. <b>3</b> p.m. <b>1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>APOLIS</b> (County) <b>Mo.</b> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. L. [Signature]</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>[Signature]</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3-24-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF</b>	22d. LOCATION (City, town, or county) <b>APOLIS</b> (State) <b>Mo.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. [Signature]</b>		24a. REC'D BY REGISTRAR <b>26 58</b> 24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BURMAN A. B.

MAR 10 1900

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02811

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEST GATE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LAURENCE AVE</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEST GATE</u> d. STREET ADDRESS <u>LAURENCE AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>LINDA</u> Middle <u>SUE</u> Last <u>TUCKER</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>20</u> Year <u>1958</u>		<b>5. SEX</b> <u>F</u>									
<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-12-55</u>									
<b>9. AGE</b> (In years last birthday) <u>2</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min										
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>NORMAN J. TUCKER</u>									
<b>14. MOTHER'S MAIDEN NAME</b> <u>EDITH CRIDER</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>									
<b>17. INFORMANT</b> <u>Mrs. Lucille Hall</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd degree burns entire body</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u> sudden </u>									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>											
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>House fire</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>3-20-1958</u>											
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Adas rd</u>									
<b>20g. (County)</b> <u>Adas rd</u>		<b>20h. (State)</b> <u>Mo.</u>		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>E. Linhardt</u>		<b>EXAMINER'S NAME</b> (Type) <u>E. Linhardt</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>3-24-58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>CEDAR BLUFF</u>									
<b>22d. LOCATION</b> (City, town, or county) <u>Annapolis</u>		<b>22e. (State)</b> <u>Mo.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Taylor</u>									
<b>23a. ADDRESS</b> <u>Sos Annapolis, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE MAR 26 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. J. ...</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 21 1903

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, it may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2842

CERTIFICATE OF DEATH

03070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b> c. LENGTH OF STAY IN 1b <b>2ys, 11mos, 26d</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital, Md.</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>927 Harford Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Richards</b> Last <b>Tynes</b>				4. DATE OF DEATH Month <b>3</b> Day <b>31</b> Year <b>19 58</b>			
5. SEX <b>Fem.</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/15/1901</b>	
9. AGE (In years last birthday) <b>56</b> yrs		IF UNDER 1 YEAR Months <b>56</b> Days <b>31</b> Hours <b>19</b> Min <b>58</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Alexander Richards</b>				14. MOTHER'S MAIDEN NAME <b>Julia Anna</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Hospital Records</b> Address <b>-----</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>260X</b> DUE TO <b>Decubital Ulcers</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Diabetes Mellitus and Arteriosclerosis</b> (b) <b>-----</b> (c) <b>-----</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>-----</b> 19 <b>-----</b> p. m. <b>-----</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>55</b> , to <b>March 31</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>March 31</b> , 19 <b>58</b> , and that death occurred at <b>3:30A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>3/31/58</b>							
ACTUAL SIGNATURE <b>Hildegard Heard Reissmann</b> M.D.				PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>4/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Ann Arundel County Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William C. March</b> ADDRESS <b>928 E North Ave</b>				24a. REC'D BY REGISTRAR <b>APR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

MEDICAL CERTIFICATION

BUREAU V. 2

1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician and completely filled in by the general director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2843

## CERTIFICATE OF DEATH

Reg. Dist. No.

02812

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANN'S NURSING HOME</u>		d. STREET ADDRESS <u>RED - 2 Bx 280 B</u>	
3. NAME OF DECEASED (Type or print) <u>Ruth J. UODUSEK</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-6-1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Harvey B. Kershaw</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Hubbard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ora E Welsh. LPN.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Cerebral Infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Infarct</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>1 Year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension and Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 12-58</u> to <u>March 31-1958</u> , that I last saw the deceased alive on <u>March 28-1958</u> , and that death occurred at <u>1:30 p.m.</u> from the causes and on the date stated above.		DATE SIGNED <u>3-31-58</u>	
ACTUAL SIGNATURE <u>DR. JOSEPH LIPSKEY</u> M.D.		ADDRESS (street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>ODONTON, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/3/58</u>	<u>Green Haven</u>	<u>Green Haven, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Steu...</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>APR 2 '58</u>		<u>...</u>	

BUREAU V. S.

APR 2 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02813

2844

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>		c. LENGTH OF STAY IN 1b <b>1yr, 9mos, 2das</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital, Md.</b>		d. STREET ADDRESS <b>704 Westover Circle</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Frances</b> Last <b>Waller</b>		4. DATE OF DEATH Month <b>3</b> Day <b>22</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-12-1892</b>
9. AGE (In years lost birthday) <b>65</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CANNING</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO <b>221-09-1205</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Septicemia due to Decubitus Ulcers</b> <b>260 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Diabetes Mellitus</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/19</b> 19 <b>56</b> to <b>March 22</b> 19 <b>58</b> , that I last saw the deceased alive on <b>March 22</b> 19 <b>58</b> , and that death occurred at <b>3:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>3/24/58</b>			
ACTUAL SIGNATURE <b>Hildegard Heard Reissmann</b> M.D.		DATE SIGNED <b>3/24/58</b>	
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D.</b>		Crownsville State Hospital, Md.	
22a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/31/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GREEN ACRE MEMORIAL PARK</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. E. Stewart</b>		ADDRESS <b>FUNERAL HOME, SALISBURY, MD</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 14)  
 15M 10/57

2845

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02814

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last				4. DATE OF DEATH Month Day Year			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) yrs	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardio-vascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>arteriosclerotic Cardio-vascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2-3 months</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 4, 1958</u> , to <u>March 27, 1958</u> , that I last saw the deceased alive on <u>March 26</u> , 1958, and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u> DATE SIGNED <u>3-27-58</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>				ADDRESS (Street, city or town, state) <u>Mt. Road, Pasadena, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
				<u>Westeyan Chapel Cem</u>		<u>Westeyan Chapel Co. Pasadena, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REG'D BY REGISTRAR	
<u>R. B. Singleton</u>				<u>Greenmount, Md.</u>		24b. REGISTRAR'S SIGNATURE	
				DATE		<u>March 27, 1958</u>	

BUREAU V. S.

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RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02815

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Anne Arundel General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b> d. STREET ADDRESS <b>48 Madison Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>H</b> Last <b>WAYSON</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>8</b> Year <b>19 58</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 16, 1910</b>		9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mech. Helper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Auto garage</b>				11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Albert L. Wayson</b>						14. MOTHER'S MAIDEN NAME <b>Annie May Garrick</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>none</b>				16. SOCIAL SECURITY NO. <b>214-05-1020</b>		17. INFORMANT <b>Thomas G. Wayson- Brother- Annapolis, Md.</b> Address <b>Spa View Ave.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Hour <b>3:05</b> Minute <b>05</b> Month <b>March</b> Day <b>8</b> Year <b>1958</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Natural C. uses</b>		20f. (City or town) <b>Annapolis, Anne Arundel</b> (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>Elmer G. Linhardt</b> EXAMINER'S NAME (Type)						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <b>March 8, 1958</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>March 11, 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b> ADDRESS <b>Annapolis, Md.</b>						24a. REC'D BY REGISTRAR <b>MAR 11 '58</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Alfred...</b>							

BUREAU V. S.

MAR 11 1958

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02816

## 2846 CERTIFICATE OF DEATH

Items 8,9 Film G227 4-1-58 et

Reg. Dist. No. ....

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MD</u>		COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cleburne</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTO.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Plaza Manor Conv. Home</u>		STREET ADDRESS (If rural give location) <u>1739 Jefferson ST</u>					
3. NAME OF DECEASED (Type or Print) <u>CORA</u> (First) (Middle) (Last) <u>WHITE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 21 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>2-12-1899</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHAS. HAMMOND</u>				14. MOTHER'S MAIDEN NAME <u>MOLLY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Ella Collins 413 H. W. F.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
231x IMMEDIATE CAUSE (A) <u>Cerebro-vascular accident</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis general</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-12</u> , 19 <u>58</u> , to <u>3-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-18</u> , 19 <u>58</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>10234 B. Rd. N.E. Cleburne, Md.</u>		DATE SIGNED <u>3-21-1958</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-23-58</u>		NAME OF CEMETERY OR CREMATORY <u>A.A. COUNTRY</u>		LOCATION (City, town, or county) (State) <u>MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>MAR 20 58</u>				<u>[Signature]</u>		<u>1304 n. Central Ave. Balto</u>	

BUREAU V. S.

MAR 10 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2847

CERTIFICATE OF DEATH

Reg. Dist. No.

02817

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. R.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 162 Furnace Dr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 162 Furnace Dr.</u>		d. STREET ADDRESS <u>Glen Burnie Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>WILHELMIE</u> Middle <u>K.</u> Last <u>WIDMARK</u>		4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 30 1895</u>
9. AGE (In years last birthday) <u>62<sup>yr</sup></u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FERDINAND BUDDENBOHN</u>		14. MOTHER'S MAIDEN NAME <u>Anne Speer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>FAMILY</u>	
17. INFORMANT <u>above</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Decompression ataxia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cerebro Vascular Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Macular Degeneration</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>1958</u> to <u>March 12</u> 19 <u>58</u> , that I last saw the deceased alive on <u>March 11</u> 19 <u>58</u> , and that death occurred at <u>9 A</u> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bryant H. Jones</u> M.D. <u>114 Craig Road Glen Burnie Md</u>		DATE SIGNED <u>3/12/58</u>	
PHYSICIAN'S NAME (Type) <u>BRYANT H. JONES MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Burnie Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McEvelly Funeral Homes - Md</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 14 1958</u>	24b. REGISTRAR'S SIGNATURE

BUREAU V. S.

MAR 17 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02818

2767

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENDRIKA</u> Middle <u>WILSON</u> Last				4. DATE OF DEATH Month <u>MARCH</u> Day <u>3</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 9, 1872</u>		9. AGE (In years last birthday) <u>85 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Holland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Frederick Greentree- Son- Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uraemia</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ch. Nephritis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Inte yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, Corotio Vascular Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/28</u> , 19 <u>58</u> , to <u>3/3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/2</u> , 19 <u>58</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Maurice Klawans</u> M.D. <u>31 Southgate Ave. Annapolis, Md.</u> PHYSICIAN'S NAME (Type) <u>Maurice Klawans M.D.</u> <u>31 Southgate Ave. Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Millersville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>7</u>		24b. REGISTRAR'S SIGNATURE <u>Dee Smith</u>	

BUNTING V. S.

MAR 7 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6226 3-19-58 at

CERTIFICATE OF DEATH

2769

02819

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ad. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. D. General Hospital</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Richard Wilson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-23-1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>7</u>		14. MOTHER'S MAIDEN NAME <u>Martha ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-32-6658</u>	
17. INFORMANT <u>Christine Brook R 18438A</u>		Address <u>Crownsville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal Hemorrhage</u> 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured peptic ulcer</u> DUE TO (c) <u>Hunt 16 days</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-25-58</u> , 19 <u>58</u> , to <u>3-3-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-3-58</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. T. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Cottrell St</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		DATE SIGNED <u>3-3-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-8-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Sabors Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cheslerfield Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Rasett</u>		ADDRESS <u>#108 Wash. St. Annapolis Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU V. 3

BUREAU V. 3

APR 6 1958

RECEIVED

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2768

## CERTIFICATE OF DEATH

Reg. Dist. No. 02820

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS 10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>OR INSTITUTION</u> <u>ANNE ARUNDEL General</u>		d. STREET ADDRESS <u>51 College Crk. Terrace</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Herbert</u> Last <u>Woods</u>		4. DATE OF DEATH Month <u>MAR</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR: Months <u>63</u> Days <u>63</u> Hours <u>63</u> Min. <u>63</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbers Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ANNAPOLIS-Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>ANNAPOLIS-Md.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN BARNETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-07-5173</u>	
17. INFORMANT <u>MARY BASHEARS-147 Obery Court</u>		Address <u>147 Obery Court</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia, circulatory failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>peptic ulcer, hypertrophy of prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-11</u> 19 <u>54</u> , to <u>3-6</u> 19 <u>58</u> , that I last saw the deceased alive on <u>3-6</u> 19 <u>58</u> , and that death occurred at <u>17</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith Rodler</u> M.D.		ADDRESS (Street, city or town, state) <u>45 Fenwick St. Annapolis</u> DATE SIGNED <u>3-8-58</u>	
PHYSICIAN'S NAME (Type) <u>EDITH RODLER M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u> ADDRESS <u>ANNAPOLIS-Md.</u>		24a. REC'D BY REGISTRAR <u>W. H. Beach</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	
DATE <u>MAR 10 '58</u>			

# CERTIFICATE OF DEATH

BUREAU V. S.

MAR 10 1939

RECEIVED